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Nos. 02-1845 and 03-83

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IN THE

Supreme Court of the United States

No. 02-1845

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

No. 03-83

CIGNA HEALTHCARE OF TEXAS, INC. and CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

Whether Texas statutory HMO medical-malpractice claims by two patient-insureds who followed their HMOs' defective medical-necessity decisions are not just preempted, but "completely preempted" so that the state-court claims are removable to federal court?

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STATEMENT OF THE TWO CASES

A. The Texas Act.

Fundamental changes in the delivery of health care over the last 20 years led Texas to enact the 1997 Texas Health Care Liability Act (the "Texas Act"), which regulates health-insurance carriers, health-maintenance organizations (HMOs), and managed-care entities. Tex. Civ. Prac. & Rem. Code, §§ 88.001-003 (Resp't App. E; *also at* Aetna Pet. App. 56a-63a). Among other things, the Texas Act requires HMOs and other managed-care entities to exercise ordinary care when making health-care-treatment decisions that control or influence the course of treatment. Sec. 88.002(a).[1] Texas also delineated in the Act's first paragraph a definition of "[a]ppropriate and medically necessary" as what is "determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community." Sec. 88.001(1). That standard is reflected in § 88.001(10), which requires employees and agents of HMOs and managed-care entities, such as pharmacists, discharge nurses, and medical directors, to exercise the degree of care that a "person of ordinary prudence in the same profession, specialty, or area of practice" would apply. With this Act, Texas exercised its historic police power in two traditional areas of state regulation: protecting the health and safety of its citizens and regulating insurance.[2]

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1. A "[h]ealth care treatment decision" means "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Sec. 88.001(5).

2. In 1837, even before statehood, Dr. Anson Jones wrote for the Republic of Texas one of the earliest medical-practice acts. *See* Board of Medical Examiners' History, available at Texas State Board of Medical Examiners' website, www.tsbme.state.tx.us/boards/mbhis.htm.

As this Court noted in *Pegram v. Herdrich*, 530 U.S. 211, 220 (2000), "many doctors and other observers argue that HMOs often ignore the individual needs of a patient in order to improve the HMOs' bottom lines"; when an HMO receives a fixed sum to care for a group of individuals, every dollar paid out for care has an adverse effect on the company's finances. Texas chose to prevent potential abuse by insisting that HMOs and their professional decision-makers provide a minimum level of treatment: a professional medical standard of ordinary care.

Petitioners acknowledge that a state may regulate HMO medical-necessity decisions without running afoul of ERISA by imposing independent review when the patient (or doctor) and the HMO continue to disagree. The Texas legislature and then-Governor George W. Bush made a policy decision also to address another frequent problem: where instead of ignoring or opposing the HMO's medical-necessity decision, the patient-insured follows the course of treatment charted—and in many instances controlled—by his or her HMO, and the HMO's decision ends up being a medically imprudent one that causes significant harm.

The duty imposed by the Texas statute exists and operates exclusive of, regardless of, and without reference to or connection with the existence or operation of any ERISA plan. The Texas Act is unconcerned with the reason an HMO makes a medical decision directly affecting treatment—only that it does. An entity is liable under the Act if it fails to use reasonable care in deciding whether a requested treatment is medically necessary. A complaint under the Act need not allege that the HMO violated the terms of any contract; the complaints in this case contain no such allegation. Relief under the Act is limited to remedies for injuries caused by medical malpractice.

B. Utilization review and medical necessity.

Both Aetna and CIGNA were performing prospective or concurrent medical-necessity utilization review. At the time ERISA was enacted, medical-necessity utilization review was done, if at all, retrospectively. *See* R. Rosenblatt, S. Law, & S. Rosenbaum, Law and the American Health Care System 212 (1997) ("Rosenblatt") ("Prior to the late 1970s, private and public insurance plans rarely used the medical necessity . . . criteria to question the treating physician's judgment."). Beginning in the late 1970s and early 1980s, managed-care entities began performing medical-necessity reviews prospectively or concurrently. Providers and patients were required to obtain the HMO's approval before or during treatment. *See Pegram*, 530 U.S. at 219.

Through their contracts with providers, HMOs often require that doctors, hospitals, and pharmacies in their provider networks "comply" or "cooperate" with the HMO's medical-necessity decisions.[3] In part, because the providers involved, whether hospital or physician, are sometimes pre-paid by capitation (a fixed sum for all members, sick or not, paid per member per month), the medical-necessity decision is not even necessarily one about payment. In many instances the hospital or other provider may refuse to provide the treatment until the HMO gives the green light; the HMO might instead require an alternative, less expensive (although possibly less efficacious, or more dangerous) form of treatment.

The only reason for performing utilization review prospectively or concurrently is to influence the course of treatment after the insured-against peril or "hazard" has

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3. Resp't App. A and B (examples of CIGNA and Aetna provider contracts, all requiring the providers to so comply or cooperate). *See also* CIGNA Br. 26; Rosenblatt at 559 ("[n]etwork exclusion represents a potentially powerful tool for ensuring compliance with coverage and utilization review standards and guidelines.").

become imminent.[4] Texas law does not, of course, prohibit prospective or concurrent review—liability accrues only if the HMO's decision violates the statutory standard of care. CIGNA candidly concedes that its medical-necessity decisions are "imbued with *medical* judgment," CIGNA Br. 7 (emphasis added); Aetna is less forthcoming about whether it considers its medical-necessity decisions to entail the exercise of professional medical judgment.

Texas concluded that traditional malpractice law—which applied only to the physician or other medical personnel who actually provide treatment—accorded little real protection to a patient whose treatment was in practice being shaped, not by his or her doctor, but by the entity engaging in utilization review. The Texas Act therefore defined the "treatment decision[s]" subject to the duty of care (and thus malpractice liability) to include any decision "which *affects* the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Sec. 88.001(5) (emphasis added). The practical effect of this pivotal definition was to extend the protections of state malpractice standards to patients (such as Respondents) whose treatment was being shaped by HMOs and other entities through utilization

4. *See* Rosenblatt at 215, 1011; J. Scott Andresen, *Is Utilization Review the Practice of Medicine?* 19 J. of Legal Med. 431, 435 (Sept. 1998); United States General Accounting Office, *Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice* 2 (July 1998) (GAO/HEHS-98-154). The insurance term "hazard" comes from the Arab name given to ancient dice games—"al zahar." Peter L. Bernstein, Against the Gods—The Remarkable Story of Risk 12-13 (Wiley & Sons 1998). In indemnity (fee-for-service) insurance, the health insurer bets on the roll of the dice, spreading the risk or hazard that, say, 2 or 12 will come up among a number of insureds, paying those who become ill (those rolling 2 or 12). In a managed-care environment, the HMO toys with the dice *after* the roll when it performs medical-necessity review after a 2 or 12 has been rolled and the patient needs care, by trying to modulate the roll's outcome—by influencing the treatment provided.

review. These cases involve two patients who adhered to the course of treatment charted by their HMOs' medical-necessity decisions. When those decisions proved not to meet Texas's professional medical standard for an HMO, the two patients availed themselves of the Texas Act.

C. CIGNA's actions that affected Ruby Calad's treatment.

Ruby Calad was prematurely forced out of the hospital by CIGNA's discharge nurse, contrary to her doctor's medical judgment, following a complicated hysterectomy with rectal, bladder and vaginal repair. CIGNA precertified Calad for only a one-day post-surgery hospital stay (CIGNA 5th Cir. Br. 3); CIGNA's discharge nurse made a second, concurrent decision on the day Calad was discharged that continued hospitalization did not meet CIGNA's medical-necessity criteria. Calad's physical condition post-anaesthetic and her financial condition did not make days of appeal feasible. (The quickest appeal process now available under federal law is 72 hours. 29 C.F.R. § 2560.503-1(f)(2)(i).) Serious physical complications after she was home—which likely could have been avoided had she been allowed to recover a few more days in the hospital—required her emergency re-admission to the hospital a few days later. J.A. 185.

Calad's complaint alleged that the CIGNA nurse's actions did not meet the Texas Act standard of care, and that CIGNA influenced and controlled the course of treatment that Calad experienced. J.A. 180-87. The complaint did not seek any award of benefits (J.A. 188); since Calad had not remained in the hospital for additional recovery days, she had no such expenses to reimburse. Instead, Calad sought the only form of relief that could then redress CIGNA's violation of the medical standard imposed by the Texas Act. J.A. 188.

D. Aetna's actions that affected Juan Davila's treatment.

Juan Davila has severe rheumatoid arthritis post-polio and was a member of Aetna's HMO, which is not itself an "ERISA plan." His treating physician made a medical decision that Davila should have his constant pain treated with Vioxx, which indisputably is on Aetna's formulary—the list of drugs Aetna decided it would provide to all members. Aetna makes its own determinations, at any time and without notice, about the medications listed in its drug formulary, with no guidelines from or consultation with an ERISA-plan sponsor. Aetna App. 28a, 30a, 34a.[5] The formulary documentation never appeared in the record below as part of what Aetna described as the "ERISA plan" documents. The formulary attached to Aetna's brief shows Davila could get Vioxx only by first experiencing significant harm from two other types of medicine unless Aetna made a medical-necessity decision otherwise. The letter spelling out this directive was signed by an Aetna pharmacist. Aetna Pet. App. 81a.

Aetna insisted, as a medical-necessity decision, that Davila first receive a generic substitute for Vioxx that had a much higher risk of gastrointestinal toxicity and bleeding. Aetna Pet. App. 67a, 76a-77a. Although the formulary documentation states that "[g]eneric drugs are therapeutically equivalent to their brand-name counterparts," and that "generics are effective, safe alternatives to brand-name medications," Aetna App. 27a, the medical literature shows that not to be the case with regard to Vioxx. Aetna Pet. App. 76a-77a. And contrary to Aetna's inference that Davila chose not to pay for Vioxx, he could not even get his pharmacy to fill the prescription. Aetna Pet. App. 67a.

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5. An employer can exclude its employees from Aetna's formulary altogether, or exclude the availability of certain classes of drugs, but no ERISA-plan administrator or sponsor determines which drugs go into Aetna's formulary or how its step program will work. Aetna App. 26a-28a, 34a.

Davila took the generic drug Aetna insisted he try first, but after a few weeks began to experience weakness and related symptoms. He was rushed to the emergency room, where he was given seven units of blood; doctors there told him that he was within hours of dying from internal bleeding—bleeding that Davila contends was the result of Aetna's medical decision. Aetna Pet. App. 68a, 77a-78a. Five days in critical care and a readmission later, Davila now cannot take any pain medication, including Vioxx, that is absorbed through the stomach.

Davila sued under the Texas Act, alleging that Aetna had engaged in treatment-influencing medical malpractice under the Texas Act by "directly influenc[ing] and controll[ing]" his medical treatment, and that Aetna had violated the Texas Act duty of ordinary care when it insisted on the use of a cheaper alternative to Vioxx. Aetna Pet. App. 65a-69a. The complaint expressly did not "seek recovery for denial of any benefits, nor . . . payment for Vioxx," Aetna Pet. App. 70a, nor did it assert that Aetna failed to pay for the Naprosyn (which caused his injuries) or seek pre-approval for Vioxx (which he is now too seriously injured to use). No claim was made of any ERISA plan violation.

E. District court proceedings.

Because neither Calad nor Davila had pleaded an ERISA claim, and because no federal claim was apparent from the face of the state-law complaints, Petitioners submitted extensive documentation upon removing to support their defense that an ERISA plan existed and that somehow the medical decisions complained of were really only administrative determinations. In district court, Petitioners sought to cast themselves in the role of ERISA fiduciaries, though CIGNA now equivocates about whether its utilization-review discharge nurse was acting as an ERISA fiduciary administering a plan. CIGNA Br. 36 n.6 (nurse "may or may not have been" an ERISA fiduciary). Aetna now maintains that its fiduciary status is irrelevant. Aetna Br. 32 n.15.

In Calad's case, CIGNA never issued an adverse benefit determination (a formal "denial"); it did not need to do so, since Calad did what CIGNA wanted by leaving the hospital early. Davila never received any "denial" letter; Aetna wrote only to his treating physician. Aetna Pet. App. 80a-81a. Davila knew only that his HMO wanted him to have a cheaper generic drug, and that his pharmacy would not fill his Vioxx prescription. These two cases demonstrate the more frequent reality of HMO medical decision-making: Given a choice between two treatment options, the HMO's medical-necessity decisions will often assure that a patient receives the course of treatment selected by the HMO.

Despite Petitioners' argument that Calad's and Davila's claims were in essence § 502(a)(1)(B) actions, so that complete preemption supported removal, both district courts dismissed Respondents' cases after Calad and Davila expressly declined to replead to assert any ERISA claim under § 502(a). The district courts' rulings raise a puzzling anomaly: on the one hand, the courts found that regardless of how Calad and Davila pleaded their respective cases, the claims were ones under § 502 and thus could not be remanded. But on the other hand, the courts then *dismissed* what they had held were ERISA claims, maintainable only in federal court, because Respondents had not pleaded any ERISA claim. CIGNA Pet. App. 40a; Aetna Pet. App. 34a-35a. Petitioners each agreed, in their briefing to the Fifth Circuit, that neither Respondent had pleaded a claim for § 502(a)(1)(B) benefits. *See* Aetna 5th Cir. Br. 13; CIGNA 5th Cir. Br. 26, 29. Because Calad and Davila did as their HMOs medically decided, and because these cases are about HMO medical malpractice, Respondents have consistently contended they had no § 502 claim to bring.

F. *Pegram*, the Fifth Circuit opinion below, and *Rush Prudential.*

The Fifth Circuit analyzed the substance of the claims and recognized that there was no § 502(a)(1)(B) claim that Respondents conceivably could have brought. Aetna Pet. App. 16a. This Court held in *Pegram v. Herdrich*, 530 U.S. 211 (2000), that HMOs making determinations with both a medical-treatment and an eligibility aspect are not ERISA fiduciaries, and expressed "doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231. Acknowledging that allowing the plaintiff's claims for breach of ERISA fiduciary duty would have meant recognizing federal preemption of state regulation of HMO medical decisions, the Court noted that prior authority (holding that ERISA does not preempt a subject of traditional state regulation, such as the field of health care, without a clear manifestation of congressional purpose) "throws some cold water on the preemption theory." *Id.* at 237 (citing *New York State Conference of Blue Cross & Blue Shield Plans, Inc. v. Travelers Ins. Co.*, 514 U.S. 645 (1995)) ("*Travelers*").

The Fifth Circuit relied on *Pegram* to conclude that it seemed "beyond dispute that Calad's and Davila's claims involve such mixed decisions," and that Respondents could not have asserted an ERISA breach-of-fiduciary-duty claim against Aetna or CIGNA. Aetna Pet. App. 13a-14a. After looking at the substance of Respondents' claims—and not merely the remedy, as Petitioners maintain—the Fifth Circuit also concluded that "[b]ecause the [Texas Act] does not provide an action for collecting benefits, it is not [completely] preempted by § 502(a)(1)(B) under *Pilot Life* [*Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987)]." Aetna Pet. App. 20a. Any doubts about that holding, the court noted, "are eliminated by *Pegram*'s admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice." *Id.*

After both cases had been briefed and argued below, this Court issued its opinion in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), holding for the first time that states could properly regulate HMO medical-necessity decision-making without running afoul of ERISA's express preemption provision, by virtue of the insurance saving clause, 29 U.S.C. § 1144(b)(2)(A). That core holding bears directly on the Texas Act, because the Act's regulation of HMO medical-necessity decisions was found to be regulation of insurance within the saving clause on remand from this Court in light of *Rush Prudential*. *See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 314 F.3d 784 (5th Cir. 2002) ("*Corporate Health III*") (upholding the IRO provisions in a suit brought by Aetna). The Fifth Circuit had earlier upheld the Texas Act's liability provisions in certain respects as not relating to ERISA plans in the first place, a holding no party appealed. *See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir.) ("*Corporate Health I*"), *reh'g denied*, 220 F.3d 641, 643 n.5 (5th Cir. 2000) ("*Corporate Health II*"), *vacated on other grounds sub nom. Montemayor v. Corporate Health Ins.*, 536 U.S. 935 (2002)).

In the decision below, the Fifth Circuit "gleaned" that *Rush Prudential* narrowed implied complete preemption to a rule that "States may not duplicate the causes of action listed in ERISA § 502(a)" to allow participants to obtain remedies that Congress rejected. The Fifth Circuit recognized that the only case after *Pilot Life* and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), in which implied preemption has been applied was *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), where a general state tort law (not an insurance law) duplicated the elements of a substantive claim under ERISA and thus improperly expanded the available remedies from equitable relief to money damages. Aetna Pet. App. 19a-20a (quoting *Rush Prudential*'s description of *Ingersoll-Rand*).

The Fifth Circuit declined to rehear these cases *en banc*; Aetna and CIGNA then successfully petitioned for a writ of certiorari.

SUMMARY OF THE ARGUMENT

These are two medical-malpractice actions under the Texas Act. Based on unassailable principles of federalism, a state is presumptively able to regulate in the areas of its citizens' health and safety, and insurance, as Texas has done here. When that state regulation is said to collide with ERISA in such a way as to create removal jurisdiction, the *conduct* upon which the state, in exercising its police powers, has legislatively placed limits must be compared with the federal enactment to see if the latter manifests any clear congressional intent to replace state law with a substantively comparable means of redressing that harm. The Court finds implied complete preemption only where a state claim involves a matter of central concern to the federal scheme, and where the federal act creates a cause of action to replace the purportedly preempted state claim. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25-26 (1983); *see also Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2063 (2003). State-law medical-malpractice claims find neither counterpart in ERISA, particularly (but not only) because managed-care entities such as Aetna and CIGNA do not function as ERISA fiduciaries in making medical-necessity decisions. *See Pegram*, 530 U.S. at 231.

Petitioner's Questions Presented frame the issue in terms of judicially implied ERISA § 502(a) complete preemption creating removal jurisdiction. Calad and Davila address that issue first within the argument, and show that even if Petitioners have a § 514(a) conflict preemption *defense*, Respondents' Texas Act claims are not removable under § 502(a). But because Congress included in ERISA an express preemption clause with significant explicit exceptions it is necessary also to examine the plain text of those provisions, an approach consistent with this Court's precedents. In such

cases as *Ingersoll-Rand*, *Taylor*, and *Pilot Life*, the Court recognized § 502 preemption of claims that were also preempted by § 514(a), but never has it implied § 502 complete preemption *without* concomitant § 514(a) preemption. In the absence of § 514(a) express preemption, preemption solely under § 502 should not be lightly implied, if at all, particularly since § 502(a)(1)(B)'s enforcement provisions apply only to ERISA plans and ERISA fiduciaries. With § 514(a), Congress specified the circumstances in which ERISA will "supersede . . . State laws," and expressly limited the statutory preemption provision to "State laws insofar as they . . . relate to an employee benefit plan." Congress's decision not to preempt state laws that do not "relate to" an ERISA plan should control.

ERISA § 514(a) does not preempt a Texas Act medical-malpractice claim, a cause of action not dependent on an ERISA plan's existence. So after first examining complete-preemption principles under § 502 and analogous federal law from which § 502 complete preemption was derived, Respondents then show that no § 514(a) conflict preemption exists in the first place and, alternatively, that no preemption exists due to ERISA's insurance saving clause and the related federal-law exception. Section 514(b)(2)(A) saves from ERISA preemption any state law that "regulates insurance." That exemption applies to both § 502 and § 514(a) preemption; the insurance saving clause provides that "nothing in this subchapter," a formulation broader than just "nothing in § 514," will preempt state insurance regulation, and the Texas Act is a regulation of insurance for reasons identical to the Illinois statute involved in *Rush Prudential*. Respondents then return to § 502 to address Petitioners' tacit but essential argument that judicially implied complete preemption should overcome an express congressional statement of no preemption.

These cases do not involve adding a remedy to the ERISA armament; they involve medical misconduct that takes place

outside ERISA's furthest reaches. The very nature of medical errors is such that ERISA protections and remedies are irrelevant. Davila could not seek reimbursement, under ERISA or otherwise, for purchasing Vioxx out of pocket (he never bought any), or approval of future Vioxx prescriptions (he is now too sick to use it). Calad could not seek reimbursement for additional hospital days in 1999 (she did not stay longer than CIGNA said she could stay), and it was a moot point at the time she sued in 2000.

Petitioners' central contention is that there was some earlier point in time when Calad and Davila could, or should, have brought a § 502 claim for benefits. Respondents disagree; however, if a § 502 claim was appropriate at some point in time, that window of time was exceptionally brief. Calad might have sued for benefits only for a few hours after she learned of the CIGNA nurse's discharge decision and before she left the hospital. Davila might have sued only during the approximately 24-hour period between when he was denied Vioxx and when he began to take Naprosyn to relieve his severe pain. Instead, however, Respondents followed the course of treatment charted by their HMOs' medical-necessity decisions, exactly as CIGNA and Aetna intended.

By their insistence that § 502 contain the sole remedy, Petitioners overlook the natural question: Remedy *for what*? Here, one must look at the substance of the conduct at issue—medical decisions made under the rubric of "medical necessity," which if done in violation of the state medical standard of ordinary care result in liability—to see that the state-law remedy *and* the underlying substantive claim differ materially from those under ERISA. What Petitioners postulate is that if the remedy *resembles* a § 502 claim, the HMO wins, and can remove; if the state remedy *differs* from the § 502 remedy (as any state remedy almost always will), even though ERISA does not regulate the substantive conduct the HMO will still win. This was not Congress's intent.

That ERISA has no meaning in cases involving medical-judgment errors carries over into the Department of Labor's

recent regulations on appealing health insurers' decisions. 29 C.F.R. § 2560.503-1 (2002). The Department has consistently recognized ERISA's practical limits in the area of managed-care medical decisions, having not only filed numerous *amicus* briefs urging no preemption of state malpractice actions against HMOs, but having also enshrined that position in the Federal Register, in which it explained that its new appeal procedures did not "limit a claimant's ability to pursue any state law remedy that may be available as a result of a medical decision, even where such decision implicates eligibility for benefits under a plan. *See Pegram* [full citation omitted]." 65 Fed. Reg. 70246, 70254 n.34 (Nov. 21, 2000).

With its holding that HMOs do not act as ERISA fiduciaries when making "mixed" treatment and eligibility decisions, and that Congress did not intend to federalize state malpractice law, *Pegram* extends the principles first announced in *Travelers* by plainly reiterating that state law continues to control malpractice cases even where an HMO's decision has a coverage component.

Pegram expressly considered the interplay between ERISA and the Federal HMO Act of 1973; the legislative history of both § 514(a) and the HMO Act establishes that Congress meant to (and did) leave HMO quality-of-care matters to the states. While the Federal HMO Act has not received the litigation attention that ERISA has enjoyed over the years, that Act is an independent and equally fundamental force in the overall design of modern federal health-care policy; it clearly empowers the states to oversee and maintain HMO health-care quality. With the Federal HMO Act, Congress deliberately rejected the *national* quality-health-care commission prominently featured throughout early proposals and in the legislative history, ultimately concluding that the states were better suited to regulate HMO quality-of-care issues.

More fundamentally, this Court has never held that judicially implied preemption can contradict or overrule express congressional language precluding preemption. Under *Rush Prudential*, a decision not handed down until after oral argument in the cases below, Texas's regulation of HMO medical-necessity decisions falls within both the ERISA clause saving state insurance regulation from preemption, 29 U.S.C. § 1144(b)(2)(A), and the McCarran-Ferguson Act, 15 U.S.C. § 1012 (reserving the regulation of the business of insurance to the states). Even mere (defensive) conflict preemption overrides a saving clause only where state law prevents or frustrates the accomplishment of an explicit federal objective, or where it is impossible for a party to comply with both federal and state law—prerequisites absent from these cases. Section 502 implied preemption cannot trump the express exceptions to preemption made plain in § 514, both in the insurance saving clause and the federal-law exception, 29 U.S.C. § 1144(d), which incorporates and reinforces the McCarran-Ferguson Act. In its *amicus* brief in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), the United States agreed that § 502 implied preemption cannot overcome § 514's specific insurance saving clause. Respondents' claims are not preempted for this reason.

Petitioners' policy-based arguments concerning "uniformity," the HMOs' "settled expectations" of immunity from poor medical-necessity decisions, and cost considerations are belied by (among other things) the disuniformity of thousands of medical-necessity definitions applied by the various HMOs and utilization-review entities, and by objective studies showing that costs would not increase if the confusion over ERISA preemption is squarely put to rest.

The Court can accommodate both federalism concerns and the *Pilot Life/Taylor* rule by holding one of three things:

(1) ERISA does not preempt state regulation of health-care matters such as the Texas Act; (2) the insurance saving clause applies to the Texas Act under *Rush Prudential* and is not trumped by judicially implied preemption; or (3) state-court medical-malpractice claims against an HMO, even if they might be subject to a preemption defense, are not removable because they do not arise under federal law. The judgment below should be affirmed.

ARGUMENT

I. Given key principles of judicially implied complete preemption, *Franchise Tax Board* governs, and *Pilot Life* and *Taylor* should not be extended to HMO medical decisions, especially when the patient followed the HMO's incorrect medical-necessity decision.

Calad and Davila did exactly what their HMOs wanted them to do—acquiescing in the HMOs' medical-necessity decisions without seeking injunctive relief or paying for care out of pocket (assuming either was even possible) and then seeking reimbursement. When the resulting harm manifested itself, their Texas Act claims offered the only available relief, with no implication of ERISA benefits whatsoever. Aetna's and CIGNA's position rests upon an uncritical assumption that a § 502 claim for ongoing denial of financial benefits owed through an ERISA plan, such as *Pilot Life* and *Taylor* involved, is conceptually identical to a state-law claim for an HMO's past substandard medical-necessity decision. But this Court has never extended ERISA's remedial provisions beyond the confines of a plan participant's efforts to recover accrued financial benefits that were being wrongfully withheld, and has no reason to do so now. When *Pilot Life* and its progeny are properly considered under well-established preemption principles, any extension of the *Pilot Life/Taylor* rule to subsume state medical-malpractice actions is unwarranted.

A. The long-standing and formidable presumption against preemption; the Texas statute regulates medical health and safety matters, traditionally the domain of the states.

The Texas statute must be viewed in light of the Court's long history of applying a presumption against preemption of state law, especially where, as here, that state law deals with its citizens' health and safety. Analyzing the extent of congressional intrusion upon matters traditionally within state control starts with the assumption that a federal act does not supersede the states' historic police powers unless that was Congress's clear and manifest purpose. *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). And preemption of such matters "should not lightly be inferred." *Hawaiian Airlines, Inc. v. Norris*, 512 U.S. 246, 252 (1994) (quotation omitted).

Calad's and Davila's state-law statutory claims find no substitute whatever in ERISA's substantive or remedial provisions; the claims implicate general health-care issues, something the Court has repeatedly found to be the traditional province of state regulation. *Rush Prudential*, 536 U.S. at 387 (describing "reasonable medical care" as involving "quintessentially state-law standards"); *Pegram*, 530 U.S. at 237 (noting that the "field of health care" is "a subject of traditional state regulation"); *De Buono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) ("the historic police powers of the State include the regulation of matters of health and safety"); *Travelers*, 514 U.S. at 661 ("nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern"); *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985) (noting "presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause").

The Court treads only lightly upon "the constitutional role of the States as sovereign entities," *Alden v. Maine*, 527 U.S. 706, 713 (1999), recognizing that the federal government's power to impose its will on the states under the Supremacy Clause "is an extraordinary power in a federalist system." *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991); *see also Younger v. Harris*, 401 U.S. 37, 44 (1971) (states have legitimate interests that the federal government is bound to respect even though its laws are supreme). For this reason, "those charged with the duty of legislating [must be] reasonably explicit." Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 Colum. L. Rev. 527, 539-40 (1947), *quoted in BFP v. Resolution Trust Corp.*, 511 U.S. 531, 544 (1994). *See also Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 588 (1985) (O'Connor, J., dissenting) ("the autonomy of a State is an essential component of federalism"; if state autonomy is ignored, "federalism becomes irrelevant simply because the set of activities remaining beyond the reach of such a commerce power 'may well be negligible'" (internal citation omitted)). The Framers made clear that "[t]he powers reserved to the several States will extend to all the objects, which, in the ordinary course of affairs, concern the lives, liberties and properties of the people; and the internal order, improvement, and prosperity of the State." The Federalist No. 45, at 313 (James Madison) (J. Cooke ed. 1961).

By holding that the test for complete preemption was not met in these cases, the Fifth Circuit implicitly but correctly concluded that whatever sorts of complete preemption might otherwise be found within § 502(a), a properly pleaded Texas Act claim is not among them. Fundamental principles of federalism yield this result, given the importance of the "federalist structure of joint sovereigns" and the "proper balance between the States and the Federal Government." *Gregory*, 501 U.S. at 458, 459.

And whether the federal statute provides "any substitute for the traditional state court procedure for collecting damages for injuries caused by tortious conduct"—as ERISA manifestly does not—is particularly significant. *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656, 663-64 (1954) (in absence of any such substitute, the Court refused to "cut off the injured respondent from this right of recovery," noting that doing so would "deprive it of its property without recourse or compensation" and "in effect, grant petitioners immunity from liability for their tortious conduct"); *see also Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984) (in the absence of any "indication that Congress even seriously considered precluding the use of [tort] remedies," the Court declined "to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct"). Without any such substitute, plaintiffs who can establish that their injuries resulted from defendants' wrongful conduct under state law would be left wholly without a remedy, a result that should not readily be attributed to Congress. *See Ingalls Shipbuilding, Inc. v. Director, Office of Workers' Comp. Programs*, 519 U.S. 248, 261 (1997) (interpretations that are "absurd or glaringly unjust" must be avoided); *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 486 (1996) (plurality opinion) (calling "implausible" any argument that Congress "effectively precluded state courts from affording state consumers any protection from injuries resulting from a defective medical device."). *Cf. Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 223 (2002) (Stevens, J., dissenting) ("Congress, of course, has the power to enact unreasonable laws. Nevertheless, instead of blind obedience to what at first blush appears to be such a law, I think it both prudent and respectful to pause to ask why Congress would do so.").

The Texas Act applies equally to all insurers and managed-care entities, including HMOs, without any reference to or connection with an ERISA plan. *See Corporate Health I*, 215 F.3d at 535 ("[t]he provisions are indifferent to whether the health care plan operates under ERISA and do not rely on the

existence of ERISA plans for their operation."). And the dissent in *Rush Prudential* acknowledged that "were a State to require that insurance companies provide all 'medically necessary care' . . . I have little doubt that such *substantive* requirements would withstand ERISA's pre-emptive force." *Rush Prudential*, 536 U.S. at 399 (Thomas, J., dissenting). The Texas Act does nothing more than establish a state substantive standard for HMOs making medical decisions, and when the clarity of this expression of traditional state regulation of health-care matters is contrasted with ERISA's silence, state law must win out.

B. The well-pleaded complaint rule and removal; under *Franchise Tax Board*, there is no removal jurisdiction when only a state-court defense of ERISA preemption might exist.

The HMOs' argument for judicially implied removability of state-law HMO medical-malpractice claims ignores the well-pleaded-complaint rule. More seriously, Petitioners' argument disregards the very narrow bases on which the Court has previously implied complete preemption to permit removal in derogation of that rule—bases that have at their foundation some degree of meaningful remedial overlap between state law and the federal statute said to displace that claim. Here, the Court should apply the well-pleaded-complaint rule and conclude that Calad and Davila have properly raised a state claim that is subject, at most, to a federal defense of § 514(a) preemption—a defense that Texas state courts are well-equipped to apply if appropriate. *See Franchise Tax Bd.*, 463 U.S. at 14 (case may not be removed on the basis of federal defense, including defense of ERISA preemption). That is, the existence of a federal *defense* to a state-law action is insufficient to render that action one "arising under" federal law within the meaning of 28 U.S.C. § 1331; a defendant wishing to assert such a defense must do so in state court.

The well-pleaded-complaint rule of course allows a plaintiff to control whether he or she wishes explicitly to assert some federal claim (assuming *arguendo* that Calad and Davila had a federal claim to assert at the time of filing, which they did not). *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 392 (1987) (federal jurisdiction exists only when federal question is presented on the face of properly pleaded complaint; plaintiff "may avoid federal jurisdiction by exclusive reliance on state law"); *Merrell Dow Pharms., Inc. v. Thompson*, 478 U.S. 804, 809 n.6 (1986) ("[j]urisdiction may not be sustained on a theory that the plaintiff has not advanced").[6]

The Fifth Circuit's holding that only a claim duplicating an existing one under ERISA is properly preempted and thus removable under § 502(a) finds support in *Rush Prudential*. There, the Court accurately noted that since *Pilot Life*, it had found only one other state law (the one involved in *Ingersoll-Rand*) to "conflict" with § 502(a) "in providing a prohibited alternative remedy." 536 U.S. at 379. As the Court explained *Ingersoll-Rand*, the state law did not just "*duplicate*[] *the elements of a claim* available under ERISA [a § 510 claim], it converted the remedy from an equitable one under [§ 502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." *Id.* (emphasis added). *See also Franchise Tax Bd.*, 463 U.S. at 26-27 (before finding ERISA complete preemption for removal purposes, state claim must involve a "central concern" of ERISA, and ERISA must create "a federal cause of action to replace [the] preempted state . . . claim").

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6. *See also Franchise Tax Bd.*, 463 U.S. at 10, 12-14 (1983); *Gully v. First Nat'l Bank*, 299 U.S. 109, 116 (1936) ("[b]y unimpeachable authority, a suit brought upon a state statute does not arise under an act of Congress or the Constitution of the United States because prohibited thereby."); *Anderson*, 123 S. Ct. at 2065-70 (Scalia, J., dissenting) (discussing well-pleaded-complaint rule and criticizing cases finding complete preemption in derogation of that rule).

No case from this Court has held, in the § 502(a)(1)(B) context, that a state-law claim rooted in a duty other than that to properly pay a claim for ERISA benefits falls "within the scope" of § 502(a). *See Taylor*, 481 U.S. at 64.[7] Removal based on *Taylor* is limited to cases in which the complaint's allegations in fact state a claim under § 502, even though not actually citing § 502. *See id.* at 61, 66 (without mentioning § 502, complaint sought "reimplementation of all benefits" plaintiff was entitled to, and asserted only claim under state contract law; but factual allegations clearly stated a claim "within the scope . . . of § 502(a).").

Too, whether a complaint states a claim over which there is federal subject-matter jurisdiction turns on the facts as they exist when suit is filed, not on hypothetical facts or fleeting circumstances no longer applicable. Aetna and CIGNA object that Respondents would have had a § 502 claim *if* they had paid for the disputed care out of their own pockets and then sued for a refund. But whether a complaint states a federal claim depends on the actual facts, not on circumstances that might have come to pass if one or more of the parties had acted differently. *Franchise Tax Board* and *Taylor* permit a court, at most, to recharacterize the complaint actually filed, not to recharacterize an academically possible one that assumes different factual circumstances.

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7. The *Taylor* Court derived complete preemption not from § 502(a)'s text, but rather from language in the Conference Report that referred to "suits to enforce benefit rights under the plan or to recover benefits under the plan" as being considered to "aris[e] under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." 481 U.S. at 65-66 (quoting H.R. Conf. Rep. No. 93-1280, at 327 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5037, 5107). Whatever Calad's and Davila's claims are, they are neither of the types spoken of in the Conference Report.

C. Rarity of, and limitations on, judicially implied complete preemption.

Applying complete preemption presupposes that federal law specifically addresses the claim asserted in state court in a substantive manner and provides the exclusive remedial scheme (as, for example, in *Anderson*, *Taylor*, and *Avco Corp. v. International Ass'n of Machinists*, 390 U.S. 557 (1968)). But here, nothing could be further from the truth.

1. In rare cases, the well-pleaded-complaint rule is disregarded if a cause of action is one "arising under" a federal law whose "preemptive force . . . is so powerful as to displace entirely any state causes of action," *Franchise Tax Bd.*, 463 U.S. at 23, thus triggering judicially implied complete preemption and removal. *See Anderson*, 123 S. Ct. 2058 (finding state usury claim completely preempted where federal usury law provides both exclusive duplicate cause of action and exclusive remedy); *Taylor*, 481 U.S. 58 (relying heavily on *Avco* to completely preempt state claim seeking reinstatement of disability benefits and related relief, where § 502(a)(1)(B)'s enforcement scheme supplied the exclusive remedy for identical claim)[8]; *Avco*, 390 U.S. 557 (judicially

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8. Justice Scalia has questioned whether members of Congress even read their own committee reports. *Wisconsin Pub. Intervenor v. Mortier*, 501 U.S. 597, 620 (1991) (Scalia, J., dissenting) ("It is most unlikely that many Members of either Chamber read the pertinent portions of the Committee Reports before voting on the bill—assuming (we cannot be sure) that the Reports were available before the vote."). In light of this common-sense observation, one cannot reasonably assume that members of Congress are students of this Court's decisions. Whether Congress was actually aware of *Avco*'s interpretation of LMRA § 301 certainly cannot be gleaned from ERISA's text or its legislative history; the case is not mentioned. And because the LMRA, unlike ERISA, contains no express-preemption clause, it is at least as likely that Congress may have seen the struggles that courts had with § 301 before and up through *Avco*, thought *Avco* went too far, and decided to include an express-

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implying complete preemption of state-court action to enforce no-strike clause in collective-bargaining agreement, where case fell within scope of LMRA § 301, governing claims for violation of contracts between employers and labor organizations). *Cf. Anderson*, 123 S. Ct. at 2066 (Scalia, J., dissenting) (referring to *Avco* and its progeny as a "radical departure from the well-pleaded-complaint rule").

Despite the narrow confines of this Court's complete-preemption cases, discussed in greater detail below, what the HMOs are asking the Court to do is far wider in scope: for removal purposes, to judicially imply complete preemption of a statutory medical-malpractice claim that finds no substantive counterpart or remedy under ERISA even though, as shown by the scant attention the HMOs pay to the Court's restrictive view of § 514(a) "relates to" preemption, a serious question exists whether Texas Act claims relate to an ERISA plan in the first place. *See* Part II, *infra*.

In the instant cases, as in *Gully v. First Nat'l Bank*, 299 U.S. 109, 117 (1936), "[t]he most that one can say is that a question of federal law is lurking in the background, just as farther in the background there lurks a question of constitutional law, the question of state power in our federal form of government." But as the Court there noted, "[a] dispute so doubtful and conjectural, so far removed from plain necessity, is unavailing to extinguish the jurisdiction of the states." *Id.* Rather, "a right or immunity created by the Constitution or laws of the United States *must be an element, and an essential one*, of the plaintiff's cause of action." *Id.* at 112 (emphasis added). The Fifth Circuit pointed out the outcome-determinative, substantive differences between

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preemption clause and saving clause so that courts construing ERISA would not imply complete preemption that Congress did not intend. Such concededly "psychoanalytical" speculation, *see United States v. Public Utils. Comm'n of Cal.*, 345 U.S. 295, 319 (1953) (Jackson, J., concurring), would account for ERISA § 514.

a § 502(a)(1)(B) claim and those involved here: "Calad's and Davila's claims of *HMO medical malpractice* differ fundamentally from the § 502(a)(1)(B) claims we have recognized. . . . Calad and Davila assert tort claims; they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan." Aetna Pet. App. 16a (emphasis added). Because "Calad and Davila advance only state law causes of action," the Fifth Circuit observed, "a straightforward application of the well-pleaded complaint rule would deprive the federal courts of original and removal jurisdiction over their claims." Aetna Pet. App. 8a.

Avco, the foundational case for the Court's § 502 complete-preemption holdings, does not undermine the Fifth Circuit's holding. There, the company sought injunctive relief in state court for the union's work stoppages done in violation of the parties' contract, even though the company could have asserted a federal claim under LMRA § 301. Despite the unavailability of injunctive relief in federal court, the Court held that the claims arose under § 301, which Congress fashioned to "place sanctions behind agreements to arbitrate grievance disputes." *Avco*, 390 U.S. at 559. Because the suit "arose under" § 301, removal was thus proper. *Avco*'s "necessary ground of decision was that the preemptive force of § 301 is so powerful as to displace entirely any state cause of action for violation of contracts between an employer and a labor organization." *Franchise Tax Bd.*, 463 U.S. at 23 (internal quotation marks omitted). Thus, a federal claim for breach of a labor contract displaces a state claim for breach of the same contract.

Within the quite-limited context of LMRA § 301 complete preemption, and the consequent quite-limited context of ERISA § 502(a) complete preemption—restricted, at least in both *Pilot Life* and *Taylor*, to claims for financial benefits—the Court's reasoning effectuates congressional intent that § 502(a) remedies not be "supplemented or supplanted." *Pilot Life*, 481 U.S. at 56. But that is not the case here. *See* Part I.D., *infra*.

2. The Court has often declined to find the requisite nexus between an otherwise-overpowering federal statute and a state-law claim, evidencing significant limits on judicially implied complete preemption. For example, in *Caterpillar, Inc. v. Williams*, 482 U.S. 386 (1987)—decided during the same term as *Pilot Life* and *Taylor*—a unanimous Court held that state-law claims for breach of individual employment contracts were not completely preempted by LMRA § 301 even though the plaintiffs were bargaining-unit members and could have sued for breach of the collective-bargaining agreement. "[A]s masters of the complaint, however, they chose not to do so." *Id.* at 395.

Furthermore, just as with Respondents' Texas Act claims, the plaintiff's complaint in *Caterpillar* was "not substantially dependent upon interpretation of the collective-bargaining agreement. It does not rely upon the collective agreement indirectly, nor does it address the relationship between the individual contracts and the collective agreement." *Id.* Moreover, the Court noted, "it would be inconsistent with congressional intent under [§ 301] to pre-empt state rules that *proscribe conduct, or establish rights and obligations, independent of a labor contract.*" 482 U.S. at 395 (citation omitted) (emphasis added). Because Texas has "proscribed conduct" and "established rights and obligations" that are independent of an ERISA plan, *Caterpillar*'s reasoning similarly forecloses the HMOs' argument for judicially implied complete preemption in these cases.

The Court made as much clear in *Franchise Tax Board*, noting that "even under § 301 we have never intimated that any action *merely relating* to a contract within the coverage of § 301 arises exclusively under that section." 463 U.S. at 25 n.28 (emphasis added). As an example, the Court commented that "a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract." *Id.* That passage can be paraphrased to fit here: "A state

medical-malpractice suit growing out of an HMO's violation of its duty to exercise professional ordinary care in making medical-necessity decisions would not arise under § 502(a) simply because that care may have been provided under employer-sponsored HMO membership." This Court's approach to LMRA § 301 demonstrates that the mere presence of a collective-bargaining agreement somewhere in the mix of facts (just as with the mere presence of an ERISA plan somewhere in the vicinity of an HMO's medical-necessity decision) does not transmute a state claim into one arising under federal law.

Because the Court placed great weight on comments in ERISA's legislative history concerning LMRA § 301, *see Taylor*, 481 U.S. at 65-66, the Court's view of § 301's limited preemptive scope applies equally here. And that scope is plainly delineated: state-law rights that exist independent of a contract governed exclusively by federal law are not preempted. *See also Norris*, 512 U.S. at 258, 260-61 (state wrongful-discharge tort claims not completely preempted; state law, not CBA, was "only source" of right not to be discharged wrongfully); *Livadas v. Bradshaw*, 512 U.S. 107, 123 (1994) ("§ 301 cannot be read broadly to pre-empt nonnegotiable rights conferred on individual employees as a matter of state law."); *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 (1988) (§ 301 does not affect substantive rights a state may provide to workers "when adjudication of those rights does not depend upon the interpretation of such agreements."). But despite this clear-cut reading of LMRA § 301 since *Pilot Life*, many ERISA defendants (such as Petitioners here) argue for a much broader interpretation of § 502(a)(1)(B) preemption than even LMRA § 301 preemption has ever enjoyed.

D. *Pilot Life* and *Taylor* do not provide a workable rule to extend to these cases.

1. Because preemption of claims for an ongoing withholding of financial benefits is not relevant when the claim is one for defective medical care, yet another reason exists not to expand complete preemption to the instant cases. In every ERISA complete-preemption case that has come before the Court to date, the "benefit" dispute involved a claim that a participant's entitlement to financial benefits was and continued to be denied on an ongoing basis. *Cf. Pilot Life*, 481 U.S. at 53 (under § 502, "[r]elief may take the form of accrued benefits due"). Section 502(a)(1)(B) may be well suited to resolve such a claim, as in *Pilot Life* and *Taylor*, but it raises a "puzzling issue of preemption," *Pegram*, 530 U.S. at 236, when the issue is one of state medical-malpractice law. That is, when an HMO member acquiesces in the HMO's dictate concerning a medical-necessity decision and then suffers harm, no ongoing denial of financial benefits is implicated; rather, both the claim (the duty) and its remedy are grounded solely in state law. Respondents do not ask the Court to overrule *Pilot Life*, only to hold that *Pilot Life* and *Taylor* should not be extended beyond their circumscribed boundaries.

In many malpractice actions arising out of medical misjudgments in a utilization review, moreover, the patient will never even submit a claim. In Calad's case, for example, she left the hospital when a CIGNA discharge nurse told her that she must. There never was a "benefits" claim for payment to process. Frequently the inexorable result of the utilization review system, and indeed its very purpose, is that no such claims will be submitted or pursued.

2. Although ERISA itself does not define "benefits," the most sensible view is that the ERISA benefit is simply the HMO membership. Such a construction allows the Court to recognize that medical-malpractice claims arising out of an HMO's defective medical-necessity decision involve only

state medical standards and state-law remedies. This approach makes particular sense when one bears in mind that the HMO is an entity distinct from the ERISA plan. *Rush Prudential*, 536 U.S. at 359 (HMO "contracts to provide medical services" for ERISA plans); *Pegram*, 530 U.S. at 223, 227 ("[t]he HMO is not the ERISA plan"); *Travelers*, 514 U.S. at 659 (noting that ERISA plans *buy* health insurance).

In fact, at least one HMO, one jurist, and one commentator have all contended that the ERISA "benefit" should be read as limited to HMO membership; it was the precise position taken *by the HMO* in *Pegram*: "The sole benefit in the plan 'established or maintained by [the] employer' here is membership in the CarleCare HMO"; the HMO was not "'established' and is not 'maintained' by the 'employer,'" thus the HMO's "internal decisions about the arrangement or provision of health care to its members are not decisions about a benefit offered under an ERISA 'employee welfare plan.'" Pet'r. Br. at 24-25, *Pegram*, 530 U.S. 211 (2000) (No. 98-1949). Because HMO membership "is the sole benefit" under the employer's plan, the HMO's "discretionary decisions about the provision of health care for a member . . . do not constitute 'administ[ration]' or 'manage[ment]' of an 'employee welfare plan'. . . ." *Id.* at 25.

In dissenting from the denial of rehearing *en banc* in *Pegram*, Judge Easterbrook made the same point: "[I]f . . . one conceives of the CarleCare HMO system *as the benefit promised by the* ERISA *plan*, then Carle is not a 'fiduciary.' It is just the supplier of medical care. . . ." Preserving the sponsors' and participants' freedom of choice "means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan." 170 F.3d 683, 686 (7th Cir. 1999) (Easterbrook, J., dissenting). *See also* Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 Hous. L. Rev. 985, 1050 (Winter

1998) ("Jacobson") ("the [HMO] clinical decision making that results in the provision of care . . . is not a function constituting the [ERISA] plan, but is a service to the plan. . . . Consequently, the benefit would be the membership in the [HMO], not the particular medical care solicited or provided."). This reading is entirely consistent with CIGNA's management of a provider network, and with Aetna's Group Agreement and Certificate of Coverage, the latter of which plainly speak in terms of eligibility to enroll in *the HMO*, not in the ERISA plan. J.A. 27-28, 33-34, 48.

3. Even if the ERISA benefit is seen as more than the HMO membership, *Pilot Life* controls only in appropriate situations—but determining the proper context of those situations is crucial. In *Pegram*, the Court held that HMOs making determinations with both a medical-treatment and an eligibility aspect are not ERISA fiduciaries, a holding that hints at the numerous problems inherent in federalizing medical-malpractice law. *Pegram*, 530 U.S. at 231. Because allowing the *Pegram* plaintiff's claims for breach of ERISA fiduciary duty would be tantamount to recognizing federal preemption of state regulation of HMO medical decisions, the Court declined to hold that an HMO member could sue, under ERISA's fiduciary provisions, for an HMO's mixed decisions. Because "[t]he HMO is not the ERISA plan," *id.* at 227, removal jurisdiction can inhere only if an HMO is functioning as a pure ERISA fiduciary—something it is not doing when making a mixed decision such as one involving medical necessity—and thus subject to § 502(a)(1)(B)'s remedial scheme.

Pilot Life does not resolve, or even address, the present issue: what are the boundaries of the term "benefits" that appears in § 502(a)(1)(B), in the context of medical treatment when an HMO makes medical-necessity decisions in administering its own business? "Benefits" cannot logically be interpreted to include an externally mandated medical standard of ordinary care under state law, which Congress

somehow intended for ERISA to usurp without—unlike in the area of pension benefits—providing in its place any substantive rule.[9] Plainly, "ERISA has nothing to say," *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001), about medical standards of ordinary care, a topic left entirely to the states.[10]

Pegram, on the other hand, allows an HMO member to pursue a non-ERISA claim based on what the Court unanimously characterized as the "malpractice standard traditionally applied in [state-court] actions against physicians." 530 U.S. at 235. Consistent with notions of federalism and the states' traditional role in regulating health-care matters, because HMOs' medical-necessity decisions are not fiduciary in nature neither do they implicate section 502(a)'s remedies where a state-law malpractice action is involved, as the Fifth Circuit concluded: "Because the [Texas Act] does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*. . . . We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law

9. Petitioners argue that *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), "conclusively establishes that medical necessity determinations under an ERISA plan concern benefits administration, not medical treatment." Aetna Br. 35. Aside from the facts that the case involved an ongoing withholding of benefits and involved no state regulation, and that the plaintiff there filed a § 502(a)(1)(B) claim to recover financial benefits that he claimed were being wrongly denied him, *Nord* simply held that, unlike Social Security Administration regulations that require deference to a treating physician's opinion on disability, nothing in ERISA or its regulations suggest that a plan fiduciary (there, the employer) who retains absolute discretion over the ERISA plan must similarly defer to a treating physician. Moreover, disability plans do nothing to affect the medical care that a disabled person receives.

10. *See also Boggs v. Boggs*, 520 U.S. 833 (1997) (given *specific* ERISA provisions governing disposition of pension-plan benefits, ERISA preempts state community-property law that conflicts with those provisions).

under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B)." Aetna Pet. App. 20a.

4. The United States now suggests that in enacting ERISA, Congress intended to federalize medical-malpractice law as far as HMOs are concerned, and to create in place of state malpractice remedies a system for patients to rush to federal court for emergency relief. Brief of the United States 27 (citing *Wilson v. Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309 (D.D.C. 1992), in which a temporary restraining order issued in 24 hours). The United States advocates that every patient who fears injury because of an HMO's medical decision should bring, in federal court, an emergency injunction action under § 502(a). But the idea that patients in Calad's position would have the wherewithal (financial and otherwise) to find a lawyer and pursue injunctive relief while lying in a hospital bed recovering from major surgery and general anesthesia is unrealistic, to say the least. And one can only imagine the puzzlement that an immediate injunction action to force Aetna to approve Vioxx would have engendered when a court learned Davila was taking the generic drug Aetna insisted he have, presumably with some pain relief (though it would turn out to almost kill him a few weeks later).

A far more basic problem exists with the sue-for-an-injunction approach, beyond the fact that it is a theoretical one for purposes of the claims Calad and Davila did file in 2000. Federal judges would be hard pressed to deny such emergency requests for medical care, since the potential physical injury would usually be irreparable, and the patients would have no other remedy; federal judges who lack state-court expertise in medical-malpractice litigation would be required to resolve in a matter of days (or hours) issues that state courts normally determine at a far more deliberative pace. The idea that Congress meant to supersede traditional state malpractice claims by promoting tens of thousands of federal temporary-injunction actions involving medical-

necessity determinations is inconceivable. And it is belied by the United States' position in other cases and the Department of Labor's regulatory comments. *See* Part II.B., *infra*.

II. Section 502 complete preemption presupposes § 514(a) "relates to" preemption; but § 514(a)—ERISA's only express preemption provision—does not preempt claims under the Texas Act for defective HMO medical-necessity decisions.

In each of its § 502(a) cases, the Court first determined whether the state law at issue "related to" an ERISA plan within the meaning of § 514(a). *E.g.*, *Rush Prudential*, 536 U.S. 355; *Ingersoll-Rand*, 498 U.S. 133; *Taylor*, 481 U.S. 58; *Pilot Life*, 481 U.S. 41.[11] Congress specifically addressed the issue of preemption in § 514(a), and mandated preemption only of state laws that so "relate." Controlling importance should ordinarily be given to Congress's decision to restrict preemption to state laws that relate to an ERISA plan. Where a state law falls outside the scope of § 514(a) preemption, an inference of implied § 502(a) complete preemption should be drawn, if at all, only on the most compelling showing.[12] But going straight to a § 502(a) analysis before determining whether a state claim even "relates to" an ERISA plan ignores

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11. In *Pilot Life*, the Court did not reach the § 502 issue until after first determining both that § 514(a) applied, and that the common-law claim of bad faith was not saved from conflict preemption as a law that regulates the business of insurance. 481 U.S. at 47-51. Moreover, the Court discussed § 502 in the context of interpreting § 514 rather than as a stand-alone reason to find that suits such as Dedeaux's should be "treated as federal questions governed by § 502(a)." *Id.* at 51-52, 56.

12. Although theoretically a situation might exist in which § 502 complete preemption could be implied even without § 514(a) express preemption, these cases do not present such a situation. Respondents' medical-malpractice claims neither relate to an ERISA plan nor fall within the scope of § 502(a)(1)(B); the Court's ruling in these cases need be no broader than that.

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the analytical pattern of this Court's § 502(a) precedents–and presupposes a crucial fact that might or might not be true. Here it is not.

Before expanding § 502(a) judicially implied complete preemption to these two cases, the Court should thus consider what Congress explicitly said about preemption in § 514(a), and about the exceptions it carved out from that preemption. Neither the language of § 514(a) nor the policy behind ERISA shows that Congress intended to preempt a state statute giving patients the right of redress against an HMO for its flawed treatment-related decisions, where that medical-malpractice statute functions regardless of whether patients obtain HMO membership through an ERISA plan or otherwise. *See BFP*, 511 U.S. at 546 ("where the intent to override [historical state practice] is doubtful, our federal system demands deference to long-established traditions of state regulation"); *Gregory*, 501 U.S. at 464 ("[t]o give the state-displacing weight of federal law to mere congressional *ambiguity* would evade the very procedure for lawmaking on which *Garcia* [*v. San Antonio Metro. Transit Authority*, 469 U.S. 528 (1985)] relied to protect states' interests") (internal quotation marks, citation omitted).[13]

13. Because Calad's co-plaintiff, Walter Thorn, was a member of a "governmental plan" to which ERISA's preemption provisions expressly do not apply (29 U.S.C. §§ 1003(b)(1), 1144), his Texas Act claims against the same Aetna HMO involved in Davila's case have gone forward in state court. Should the Court agree with Petitioners here, identical medical-necessity decisions will be preempted (or not) depending entirely on the coincidence of who happens to pay the HMO dues or premiums. At a minimum, this should lead the Court to consider whether the actual ERISA "benefit" is the payment of HMO dues or premiums.

A. *Pegram*'s unequivocal statement that HMO "mixed" decisions are not preempted.

In *Pegram*, the plaintiff complained that her health-care provider, a group of doctors who could earn bonuses through their physician-owned HMO by minimizing care and referring patients only to facilities controlled by the group, breached an ERISA fiduciary duty. The Court disagreed. Notably, the Court did not limit its reasoning only to doctor-owned HMOs: "courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs." 530 U.S. at 222.[14] According to *Pegram*, "federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim." *Id.* at 236. But "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 237 (citing *Travelers*).

Importantly, this Court recognized in *Pegram* that HMO health-care-treatment decisions involve both administrative (eligibility) decisions and pure treatment decisions involving "the appropriate medical response" (the subject, most plainly, of state malpractice laws). *Id.* at 227-28.[15] The Court observed that these decisions "are often practically inextricable from one another," something that is so "*not*

14. Additionally, the Court noted without disapproval that the plaintiff's original malpractice claim against her HMO doctor was tried to a favorable jury verdict, *Pegram*, 530 U.S. at 217, and further noted that states vary regarding whether to "allow malpractice actions against HMOs," *id.* at 235, at the very least implying that ERISA does not bar state-law tort suits against HMOs.

15. *Pegram* defined "treatment decisions" as "choices about how to go about diagnosing and treating a patient's condition. . . ." 530 U.S. at 228. This is strikingly similar to the Texas Act's definition of a health-care-treatment decision, *see* § 88.001(5), and to what CIGNA and Aetna did here.

merely because, under a scheme like Carle's, treatment and eligibility decisions are made by the same person, the treating physician," but rather because "a great many and possibly most coverage questions are not simple yes-or-not questions"; the "more common coverage question is a when-and-how question." *Id.* at 228 (emphasis added).

Pegram's holding was premised on a recognition that ERISA does not preempt malpractice claims against an HMO whose physicians provided the assertedly inadequate care, even where the treatment decision involved a mixed treatment and eligibility determination. An HMO or other entity should not be permitted to avoid malpractice liability simply because it organizes its affairs so that—as in the instant cases—the same mixed decision is made by a physician or nurse or pharmacist who does not happen to be the patient's own treating physician.

The Court concluded that Congress "did not intend" for an HMO to be considered a fiduciary "to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231.[16] A finding of no fiduciary status with regard to mixed decisions (a category that subsumes medical-necessity decisions) is tantamount to a broader finding that ERISA does not preempt other types of claims, because if an HMO's mixed decisions are not fiduciary in nature, neither

16. The Court's "acting through its physicians" phrase does not alter the analysis, for there is no fundamental difference (certainly not in the ultimate effect) between an HMO that employs medical judgment in determining "medical necessity" and one that does so through employee physicians' (or their subordinates') own judgments. *See also supra* n.14; *Pegram*, 530 U.S. at 222 ("We think, then, that courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs.").

can they give rise to any other sort of ERISA claim.[17] *See, e.g.*, ERISA § 502(d)(2), 29 U.S.C. § 1132(d)(2) (authorizing monetary relief only against ERISA plans and fiduciaries).[18] CIGNA admits as much in its brief, noting that

17. *See also* Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest after* Pegram v. Herdrich, 36 Tort & Ins. L.J. 687, 718 (Spring 2001) ("Stempel") (Based on *Pegram*, if HMO is "essentially a vendor providing supervised medical services," ERISA should not preempt claims "merely because this vendor attempts to manage its delivery of services" in such a way as to lower costs and increase profits "in connection with its contract with an ERISA plan.").

> [A]ccording to *Pegram*, HMOs are almost never fiduciaries under an ERISA plan and are almost never subject to fiduciary liability under ERISA. Logically, these same HMOs can almost never be pure plan administrators subject to ERISA preemption and immunity. Hence, actions against them will almost never affect the ERISA plan in a way that warrants preemption. Rather, state law claims against the HMO relate to the HMO and its performance.

Id. at 722. *See also Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, 72 U.S.L.W. 3093 (U.S. July 11, 2003) (No. 03-69).

18. CIGNA equivocates about whether it was functioning as some sort of ERISA fiduciary (*e.g.*, CIGNA Br. 35-39)—the only way in which it can try to gain ERISA's protections against liability for its medical malpractice. Aetna, on the other hand, claims that it "makes no difference whether or not Aetna was acting in a fiduciary capacity" (Aetna Br. 32 n.15), presumably because the Group Agreement between it and Davila's employer conclusively establishes just the opposite. J.A. 31. But in fact the HMOs' status *does* make a difference. If an HMO is not a fiduciary, ERISA affords no means to recover a money judgment against it; even if it is nonetheless a fiduciary in some limited administrative sense, the HMO then runs into *Pegram*'s holding that "mixed" decisions take it outside that realm for purposes of a state malpractice claim.

a state malpractice claim, even when "mixed" with a "benefit determination" would "not require the plaintiff to prove a breach of the terms of the ERISA plan, only that the treatment itself was improper." CIGNA Br. 33 n.5.

B. The Department of Labor's agreement, both before and after *Pegram*, that ERISA does not preempt an HMO's mixed decisions.

The position now taken by the United States is inconsistent with interpretations of ERISA previously advanced by the Department of Labor. The Department adopted Respondents' reading of *Pegram* in *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pennsylvania Hosp. Ins. Co.*, 536 U.S. 938 (2002). *See* Secretary of Labor Br., 2000 WL 34016555 (Sept. 22, 2000). The Department read *Pegram* as establishing that § 514 "does not preempt state law that applies to the HMO's medical treatment decisions, even when they are what the Court described as 'mixed' treatment and eligibility decisions," *id.* at *9, and that mixed decisions "are governed by state malpractice standards and not by ERISA fiduciary standards," *id.* at *11. Following *Pegram*'s approach, then, the Department of Labor concluded that the Pennsylvania Supreme Court "should hold that [the HMO] may have made a 'mixed' treatment and eligibility decision and, *if it did, ERISA does not preempt a state negligence action challenging the decision*." *Id.* at *11-12 (emphasis added).

Explaining further, the Department found "no . . . manifestation of preemptive intent with respect to the general category of treatment decisions that are intertwined with eligibility determinations by an HMO, i.e., coverage decisions that involve or implicate medical judgments. . . ." *Id.* at *12. Because "ERISA's overriding purpose is to protect the interests of participants and beneficiaries" by "round[ing] out the protection afforded participants by eliminating the

threat of conflicting and inconsistent State and local regulation," *id.* at *12-13, preemption would undermine those goals "if an HMO can escape responsibility as an ERISA fiduciary for its 'mixed eligibility decisions,' as *Pegram* holds, and also avoid state malpractice law," *id.* at *13.

Even before *Pegram*, the Department of Labor advanced this view in its *amicus* brief to the Fifth Circuit in *Corporate Health I*. Br. of Secretary of Labor, *Corporate Health I* (Nos. 98-20940 & 98-20981) (Mar. 12, 1999). There, the Department correctly recognized that the Texas Act liability provisions in their entirety do not "relate to" ERISA plans, because when a managed-care entity acts as an arranger and provider of medical treatment, "it is operating in a traditional sphere of state regulation, the provision of health care, which the Supreme Court has said is not preempted absent a clear expression of Congressional intent." *Id.* at 7 (citing *Travelers*). As early as 1998, the Department of Labor had filed *amicus* briefs in eight other cases, arguing every time that "ERISA does not preempt negligence or medical malpractice claims against HMOs when the plan participant is part of an employer-based health plan." United States General Accounting Office, *Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice* 20 and n.38 (July 1998) (GAO/HEHS-98-154) (collecting cases).

The 2002 Department of Labor regulations to which Petitioners refer, 29 C.F.R. § 2560-503-1 (setting out claim and review procedures applicable to employee benefit plans, including group health plans), do not impose any substantive regulation of the *quality* of a particular medical-necessity decision, something (again) left entirely to state law.[19]

19. As CIGNA makes clear, 29 C.F.R. § 2560.503-1 was not promulgated until *after* the events in both Calad's and Davila's cases had occurred. CIGNA Br. 44. Furthermore, the Department of Labor regulations contain the same exception to preemption found in ERISA § 514(b)(2)(A) for state insurance regulation. 29 C.F.R. § 2560.503-1(k).

In commentary accompanying its proposed new regulations, the Department noted that those regulations "did not address section 514 . . . *or in any way propose to regulate* the relationship between the proposed minimum standards for benefit claims procedures of employee benefit plans and *State law that might affect or relate to such standards*." 65 Fed. Reg. 70246, 70254 (Nov. 21, 2000) (emphasis added).

More notably, the Department took the same position concerning *Pegram* that the Fifth Circuit did below: "Nothing in this regulation should be construed to limit a claimant's ability to pursue any state law remedy that may be available *as a result of a medical decision, even where such decision implicates eligibility for benefits under a plan. See Pegram* [full citation omitted]." 65 Fed. Reg. 70246, 70254 n.34 (emphasis added). The Department of Labor thus recognized that the classic situation for implying preemption—an impossible conflict with federal law, or frustration of congressional purpose, *e.g.*, *Geier v. American Honda Motor Co.*, 529 U.S. 861 (2000)—simply does not exist. *See also Hillsborough County*, 471 U.S. at 714 (preemption argument faced "uphill battle" (and lost) where federal agency stated that its regulations were not meant to be exclusive, and were not intended to usurp state powers).

C. The plain text of § 514(a): "supersede"; the absence of anything in ERISA or its regulations to supersede state laws regulating the substantive quality of medical decisions.

ERISA "supersede[s] any and all State laws" that "relate to" an employee-benefit plan. 29 U.S.C. § 1144(a). The Court has construed the word "supersede" to ordinarily mean "'to displace (and thus render ineffective) *while providing a substitute rule*.'" *Humana, Inc. v. Forsyth*, 525 U.S. 299, 307 (1999) (quoting Br. for United States as *Amicus Curiae* 17, n.6) (emphasis added); *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 136 (1992) (Stevens, J., dissenting) (emphasizing that ERISA uses the

word "supersede"—meaning to replace, not to nullify—rather than "preempt," and concluding that "if we were to decide this case on the basis of nothing more than the text of the statute itself, we would find no pre-emption (more precisely, no 'supersession') of the District's regulation of health benefits . . . because that subject is entirely unregulated by ERISA"); Jacobson, 35 Hous. L. Rev. at 1003 (pointing out difference between "supersede" and "preempt," and noting that plain-language interpretation "would demand that ERISA only supersede state laws that regulate an area of employee benefit plans already covered by ERISA.").

A "substitute rule" dealing with the situation at hand, where an HMO member has been harmed by a defective HMO medical-necessity treatment decision, is nowhere to be found in ERISA, or in any Department of Labor regulation. *See also Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 16 (1987) ("It would make no sense for pre-emption [of state severance-pay law] to clear the way for exclusive federal regulation, for there would be nothing to regulate" because no administrative activities—ERISA's overriding regulatory concerns—were involved). To the contrary, if ERISA preempted state medical-malpractice claims, patients in need of relief for HMO medical malpractice are left in a statutory abyss. *See, e.g., DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 467 (3d Cir. 2003) (Becker, J., concurring) (finding it "unlikely that Congress intentionally created this so-called, 'regulatory vacuum,' in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute").[20]

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20. Although Petitioners describe at length what they consider "remedies" that Respondents could have pursued under a different set of facts (*e.g.*, filing an injunction action, or paying for care out of pocket and then seeking reimbursement), they neatly side-step what sort of "remedy" is available under ERISA when an HMO member does exactly what the HMO says and accepts its medical-necessity determination, but to great resulting harm. Of course, there is none.

D. The Court's tempering of a previously expansive view of "relates to" preemption; Congress did not intend to preempt state health-care quality standards.

This Court long ago commented that § 514 is "not a model of legislative drafting," *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), but construed it literally—at least initially—in the broadest possible terms, to apply if a state law had a "reference to" or even a "connection with" an ERISA plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). *See also Pilot Life*, 481 U.S. at 45-47; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Even under such a broad reading, the Court recognized that § 514 had its limits: "Congress pre-empted state laws relating to *plans*, rather than simply to *benefits*." *Fort Halifax*, 482 U.S. at 11.

Despite its early sweeping interpretation of "relates to" preemption, a unanimous Court later recognized the unworkable nature of casting the preemptive net too widely: "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere." *Travelers*, 514 U.S. at 655 (internal punctuation, citation omitted). Instead, "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here." *Id.* With *Travelers*—which held not preempted a state law requiring hospitals to collect surcharges from patients insured by commercial carriers but not patients insured by a Blue Cross/Blue Shield plan—the Court put an end to an unnecessarily literal interpretation of § 514's "relates to" language.

The *Travelers* Court first dismissed the idea that the state law made "reference to" ERISA plans. As with the Texas Act, the state surcharge law was imposed "regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private

purchase, or otherwise. . . ." *Id.* at 656. In next turning to *Shaw*'s "connection with" test, the Court conceded that "here an uncritical literalism is no more help than in trying to construe 'relate to.' For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections." *Id.* Instead, courts "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive [preemption]." *Id. See also Boggs*, 520 U.S. at 841 (eschewing "relates to" analysis and instead simply asking whether state law "conflict[ed] with the provisions of ERISA or operate[d] to frustrate its objects.").

A surcharge law that had only an indirect economic effect on "choices made by insurance buyers, including ERISA plans," did not relate to an ERISA plan: such an influence "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . ." *Travelers*, 514 U.S. at 659. And there was more:

> [T]he existence of other common state action with indirect economic effects on a plan's costs leaves the intent to pre-empt even less likely. *Quality standards*, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits.

Id. at 660 (emphasis added). Moreover, the *Travelers* Court observed that Medicare's history "confirm[ed] that Congress never envisioned ERISA pre-emption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation. . . ." *Id.* at 667 n.6. If the states were left free to "experiment" with health-care *cost* controls, surely Congress left them the same freedom when it came to health-

care *quality* standards, a far more venerable area of historic state police power.

At bottom, then, *Travelers* rested upon two notions: (1) state laws with "only a tenuous, remote, or peripheral connection with covered plans" were not preempted; and (2) "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661. The Texas Act claims raised here fall within both rationales.

Two years later, the Court noted that because ERISA did not modify the "starting presumption that Congress [did] not intend to supplant state law" falling within areas of traditional state regulation, a party raising preemption "bear[s] the considerable burden of overcoming" that presumption. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) (holding that even a direct tax on an ERISA plan does not require a finding of state-law preemption); *see also California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 330 (1997) (there must be an "indication in ERISA [or] its legislative history of [an] intent on the part of Congress to pre-empt" a "traditionally state-regulated *substantive* law.") (internal alterations, emphasis added).

The trilogy that comprises *Travelers*, *De Buono*, and *Dillingham* thus applied a common-sense interpretation to the seemingly infinite reach of § 514's "relates to" language. Of particular note is the following passage from *Dillingham*, a case (like *Travelers*) holding that simply because a state law has an economic impact on ERISA plans, that impact is too tenuous to justify preemption:

> Indeed, if ERISA were concerned with any state action—*such as medical-care quality standards* . . .—that increased the costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach . . .

Dillingham, 519 U.S. at 329 (emphasis added).[21]

The Court's retrenchment from the virtually limitless view of ERISA *conflict* preemption that inhered when it decided *Pilot Life* and *Taylor* is critical to a proper view of what kinds of disputes about "benefits" fall within the scope of § 502(a)(1)(B). The Court has now clearly distinguished between purely administrative decisions (such as eligibility), and the far more common ones involving both a coverage and a treatment decision, the examination of which under ERISA would require developing a body of federal malpractice—something the *Pegram* Court expressly disavowed. Even though the more circumspect approach to § 514 taken by this Court and by the Department of Labor (at least until recently) goes far toward reconciling congressional expressions of preemption with principles of federalism, a thorough examination of that section's effect on Respondents' claims would be incomplete, as *Pilot Life* teaches, without also considering § 514(a)'s legislative history.

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21. *See also Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring)

> [A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. [Citation omitted.] The statutory text provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended—which it is not. I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the 'relate to' clause . . . is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating 'employee benefit plan[s]'.

E. Section 514(a)'s legislative history, considered anew in light of the preceding year's Federal HMO Act and its legislative history.

In *Pegram*, for the first time in ERISA jurisprudence the Court made explicit the usefulness of also considering the Federal HMO Act of 1973, 42 U.S.C. § 300e, *et seq.*, passed during the same congressional term and just a year before ERISA; that Act's legislative history shows that Congress intended the states to regulate HMO medical quality—exactly as Texas has done here. This congressional intent is in harmony with ERISA's legislative history.

1. The enacted version of § 514(a) was drafted in conference, and the Court has (correctly) observed that there is little legislative history explaining how far it extends. *See, e.g., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (characterizing the legislative history as "sparse"). The changes to § 514—made a mere ten days before final congressional action on ERISA—passed "without serious discussion of their significance." Rosenblatt at 174. The dissent in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), attempted to reconcile the early and final versions of § 514 as "an editorial amalgam of the two bills rather than as a major expansion of the section's coverage."[22] Applying the presumption against invalidating generally applicable state rules "leads me to the conclusion that the pre-emption clause should apply only to those state laws that

22. Early versions of § 514 discussed its preemptive effect as concerning either state laws "relat[ing] to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans" (H.R. 2, 93rd Cong., 1st Sess., § 114 (1973), *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print), at 50-51 ("Leg. Hist.")), or state laws that "relate to the subject matters regulated by this Act" (S. 4, 93rd Cong., 1st Sess., § 609(a) (1973), *reprinted in* 1 Leg. Hist. at 186). The conference report did not explain why or how these specific preemption provisions from both chambers became transmuted in conference into the final language.

purport to regulate subjects regulated by ERISA or that *are inconsistent with ERISA's central purposes*." *Id.* at 67 (Stevens, J., dissenting) (emphasis added).

The House Committee on Education and Labor made clear that § 514(a)'s core purpose was to establish uniform federal standards regarding certain aspects of *pension* plans:

> Except where plans are not subject to this Act and in certain other enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law *in the areas of vesting, funding, insurance and portability standards, for evaluation of fiduciary conduct, and for creating a single reporting and disclosure system in lieu of burdensome multiple reports.*

House Comm. on Education and Labor, H.R. Rep. No. 93-533, at 17, *reprinted in* 2 Leg. Hist. at 2364 (emphasis added). *See also* Senate Comm. on Labor and Public Welfare, S. Rep. No. 93-127, at 35, *reprinted in* 1 Leg. Hist. at 621 (same). Neither the House nor the Senate Committee expressed concern with state laws beyond those that might affect the highlighted subjects. *Cf.* Jacobson, 35 Hous. L. Rev. at 998 ("In thousands and thousands of pages, welfare benefit plans are mentioned only a handful of times.")[23]

23. *See also* Donald T. Bogan, *Protecting Patients' Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?* 74 Tul. L. Rev. 951, 972, 976-77 (Feb. 2000) ("Bogan") ("ERISA's legislative history provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans"; "[t]here is no documentation anywhere in ERISA's legislative history of any study or investigation of the history or growth of non-pension benefit plans, or of any specific concern with the management of nonpension plan assets. . . .").

Senator Javits, one of ERISA's sponsors, extolled ERISA as "nothing less than a pension 'bill of rights,'" 3 Leg. Hist. at 4751, and discussed what § 514 was intended to accomplish: "State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans . . . establishing State termination insurance programs, et cetera, will be superseded." 3 Leg. Hist. at 4771. This statement is both consistent with ERISA's goals of protecting workers, *see* 29 U.S.C. § 1001, and indicative of the types of state regulation that Congress had in mind to preempt.

2. Further, the Federal HMO Act, 42 U.S.C. § 300e *et seq.*, enacted just a year before ERISA and during the same congressional term, shows that Congress intended the *states* to regulate HMO quality and never contemplated that HMOs would be able to commandeer the practice of medicine through a statute (ERISA) requiring almost unquestioning deference to a (putative) plan administrator's "benefit" decision. Stated another way, there is no demonstrable congressional intent to immunize a process whereby HMOs decide what care is appropriate—that is, medically necessary—including such things as the "when-and-how question[s]" that arise when "physicians . . . decide what to do in particular cases." *Pegram*, 530 U.S. at 228-29. The role of state regulation of HMO medical decisions contemplated by the Federal HMO Act is inconsistent with a construction of ERISA that would immunize HMOs that violate state standards for treatment decisions.

Though Congress explored implementing comprehensive federal regulation of HMO quality through a Commission on Quality Health Care Assurance, it ultimately decided *not* to create such a commission, instead leaving quality-of-care

regulation to the states.[24] But even while such a Commission was being considered, the 1973 Senate Report reflected a "decision to encourage states to develop their own standards [regulating HMO conduct]" because "experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards." Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 93rd Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. at 3077, 87 Stat. 914.

At bottom, it makes no sense to suppose that just one year after adopting the federal HMO Act—and deliberately leaving HMO quality-of-care standards to the states—the same term of Congress intended through ERISA to usurp the states' ability to regulate the quality of medical care that HMOs provide, without a word so indicating. The legislative history of these two acts shows a Congress not only unconcerned with preempting state medical-quality regulation (through ERISA's total silence on this issue) but in fact, through the HMO Act, intent on preserving and encouraging state regulation and oversight in that very area.

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24. Much of the 1973 Senate Report dealt with the proposed commission, *see* S. REP. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, but the actual HMO Act dropped it altogether when finally enacted. The Court has more than once considered Congress's rejection of a proposed statutory provision in construing an act's final language and the congressional intent behind it. *See, e.g., Crosby v. National Foreign Trade Council*, 530 U.S. 363, 378 n.13 (2000) (fact that "Congress repeatedly considered and rejected targeting a broader range of conduct lends additional support to our view"); *Blau v. Lehman*, 368 U.S. 403, 410-12 (1962) (inferring scope of potentially liable parties under federal insider-trading statute from Congress's early drafts).

III. Even if the Texas Act were otherwise conflict preempted under § 514(a), two express exceptions to preemption—the insurance saving clause and the federal-law exception—apply here.

The Texas Act is saved from any arguable preemption by virtue of two statutory exceptions in ERISA: the insurance saving clause and the federal-law exception. These exceptions reveal additional problems with relying on *Pilot Life* and *Taylor* in this context, inasmuch as both cases first found § 514(a) preemption *and* the inapplicability of the insurance saving clause before judicially implying § 502(a) complete preemption. Following the pattern of this Court's precedents, even if conflict preemption is found to exist the Court should also consider whether any exception to that preemption is present before reaching the § 502(a) issue. And that inquiry is made by looking at Congress's expressed intent, as determined from the plain text of what it said in enacting exceptions to ERISA preemption. Notably, the insurance saving clause provides that "nothing in this subchapter"—not merely "nothing in § 514"—shall preempt state insurance regulation; the plain language of § 514(b)(2)(a) thus applies to § 502 as well.

The instant cases were argued before *Rush Prudential* was handed down and thus before this Court held that state regulation of HMO medical-necessity decisions falls within ERISA's insurance saving clause. (The Fifth Circuit did briefly discuss *Rush Prudential*, though not on this point. Aetna Pet. App. 19a-20a.) Both Petitioners cite *Rush Prudential* extensively yet overlook its core holding: state regulation of HMO medical-necessity decisions is removed from § 514(a)'s preemptive scope by the insurance saving clause. In light of *Rush Prudential*'s issuance after briefing and argument below, Respondents discuss the insurance-exception here in the context of proposed § 502 complete

preemption.[25] A prevailing party may advance any ground supporting a judgment below in its favor so long as it would not modify the judgment. *Trans World Airlines, Inc. v. Thurston*, 469 U.S. 111, 119 n.14 (1985); *Dandridge v. Williams*, 397 U.S. 471, 475 n.6 (1970). And because Petitioners' Question Presented of § 502 preemption is one of judicial implication, the Court considers any express-preemption and saving-clause issues before implying preemption. *E.g.*, *Geier*, 529 U.S. 861; *International Paper Co. v. Ouellette*, 479 U.S. 481 (1987). The insurance saving clause's encompassing of Texas regulation of HMO medical-necessity decisions is "fairly included" in the Question Presented. Sup. Ct. R. 14.1(a).

A. *Rush Prudential*'s holding that state regulation of HMO medical-necessity decision-making falls within the insurance saving clause; Texas Act not preempted because saving clause preserves "any" and "all" state laws regulating the business of insurance.

ERISA § 514(b)(2)(A) provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." The Court has construed the saving clause as being phrased with similar breadth as § 514(a)'s conflict-preemption clause. *E.g.*, *Metropolitan Life*, 471 U.S. at 739-40, 746 ("while the

25. Respondents touched briefly upon the saving-clause issue in their briefing to the Fifth Circuit, noting that the Court had granted certiorari in *Rush Prudential* and that the insurance saving clause was involved. Calad 5th Cir. Br. 24 n.44; Davila 5th Cir. Br. 29 n.55. And in a post-argument letter brief that is part of the Fifth Circuit record, Respondents pointed out that *Rush Prudential* "held that Illinois' independent review provision . . . was not preempted by ERISA, given that the IRO provision was limited to 'medical necessity' determinations," and that cases brought to the appellate court's attention post-argument, including *Rush Prudential*, "affirm the right of the states to regulate HMOs when they practice medicine through so-called 'medical necessity' decisions. . . ."

general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation"; "[n]othing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause.").

And as with health-care matters, insurance has always been viewed as a special area of state regulation to be zealously protected from federal control. *See id.* at 744 n.21 ("Congress' 'primary concern' in enacting McCarran-Ferguson was to 'ensure the States' continued ability to regulate the business of insurance.'"). Moreover, as the U.S. Chamber of Commerce has observed—in its *amicus* brief supporting Petitioners—"[s]tate insurance law provides a *real safeguard against abuses by HMOs*. As this Court has established, HMOs are subject to state insurance laws." Chamber Br. 20 (emphasis added). *Cf. Rush Prudential*, 536 U.S. at 399 (Thomas, J., dissenting) ("were a State to require that insurance companies provide all 'medically necessary care' . . . I have little doubt that such *substantive* requirements would withstand ERISA's pre-emptive force."). Texas has taken a realistic approach to such insurance regulation by requiring HMOs to exercise ordinary care in making medical-necessity determinations.

At issue in *Rush Prudential* was whether Illinois could impose an independent-review process upon an HMO's medical-necessity determinations; rejecting the HMO's various challenges to the state IRO law, the Court held that the Illinois law was indeed saved from preemption.[26] As a threshold matter, the Court found that because HMOs without question assume risk (even though they might also do other things), they fall within the definition of "insurers." *Rush Prudential*, 536 U.S. at 367-70; *see also Pegram*, 530 U.S. at 218-19 (HMOs are

26. The Illinois Attorney General and Petitioners treated § 514(a) preemption as a given; Illinois argued the case entirely upon the insurance exception and never challenged whether § 514(a) applied at all. And it does not. *See* Part II, *supra*.

"risk-bearing organizations," because they generally "assume[] the financial risk of providing the benefits promised").

And even if CIGNA was acting as a third-party administrator, that status does not change the result; a state insurance law's possible incidental effects on non-risk-bearing entities do not suffice to remove it from the saving clause. *Rush Prudential*, 536 U.S. at 371 ("Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan."). *See also Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1476 n.1 (2003) (Kentucky any-willing-provider laws "apply to all HMOs, including HMOs that do not act as insurers but instead provide only administrative services to self-insured plans"; HMO activity in providing administrative services to self-insured plans "suffices to bring them within the activity of insurance for purposes of § 1144(b)(2)(A)").[27] In any event, Calad's original petition, which must be taken as true for purposes of determining removal jurisdiction, alleges that her membership in CIGNA's Exclusive Provider Program ("EPP") was "an insurance plan, not a self-funded plan." J.A. 184; *see also* Calad 5th Cir. Br. 6 (same). CIGNA conceded below that in this circumstance a "plaintiff's pleading controls whether removal is appropriate." J.A. 195.

The EEP appears to be at least a CIGNA-managed network of providers, doctors, and hospitals contracting with CIGNA, if not actually an HMO.[28] And it is also undisputed that CIGNA

27. Here, both Aetna and CIGNA fall under the jurisdiction of the Texas Department of Insurance, as evidenced by (among many other things) the form provider contracts each is required to file. Resp't App. A, B; *see also* J.A. 150.

28. CIGNA's status is the subject of a factual dispute: Calad's state-court petition asserted without objection that CIGNA was an HMO. (The United States' *amicus* brief in support of Petitioners also refers to Petitioners as "HMOs." Sol. Gen. Br. 29.) Though there is

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acts as a managed-care entity in making medical-necessity decisions communicated to its provider network; CIGNA stated, in its notice of removal, that Calad "did not qualify under *CIGNA*'s medical necessity criteria. . . ." J.A. 196 (emphasis added). *See also* CIGNA Br. 3 (medical-necessity determinations are made by "nurses and consultant physicians in the designated review organization"). Ryland, not CIGNA, is denominated as the Ryland Plan Administrator. J.A. 281. Aetna administers its "HMO" in deciding medical necessity in connection with its formulary. J.A. 25. ("This is a Group Agreement between Aetna U.S. Healthcare of North Texas, Inc. (hereinafter referred to as HMO". . .). That Aetna was not acting as the ERISA-plan administrator is further evidenced by Aetna's agreement with Davila's employer, which states that "[n]either party is an agent nor employee of the other." J.A. 31.

In *Kentucky Association*, the Court significantly (and unanimously) completed the change in McCarran-Ferguson analysis previously applied in the ERISA context by simplifying the inquiry it began in *Rush Prudential*. In determining whether a state law is saved under § 514(b)(2)(A), the Court imposes only two requirements: "First, the state law must be specifically directed toward entities engaged in insurance [citing *Pilot Life*, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), and *Rush Prudential*]. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured." 123 S. Ct. at 1479. Because Kentucky insureds could not seek insurance from a closed network in exchange for a lower premium, "[t]he AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer." *Id.* at 1478.

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some evidence that Calad's employer had a self-funded plan, there are other indications that CIGNA was in fact acting as a managed-care entity in coordinating a provider network, not just administering a self-funded plan. In this procedural posture the complaint's allegations are presumed to be true and viewed in the light most favorable to the plaintiff, as CIGNA admitted below.

The Texas Act's liability provisions similarly affect risk arrangements, for two primary reasons, among many others. First, like the IRO provisions upheld in *Rush Prudential*, they "exclude[] insureds from joining an HMO" that would impose subjective medical-necessity criteria free from external, state-imposed ordinary-care criteria "in exchange for a lower premium." *Kentucky Ass'n*, 123 S. Ct. at 1476. Second, like *UNUM*'s notice-prejudice rule, which "dictates to the insurance company the conditions under which it must pay for the risk that it has assumed," *id.* at 1477 n.3, the Texas Act substantially affects the risk-pooling arrangement by dictating to HMOs and their employees and agents the conditions under which they must respond to the risks (illnesses) assumed—*e.g.*, employing that "degree of care" that a similarly situated person in the "same profession, specialty, or area of practice" (here, a pharmacist and a physician or nurse) would use. Texas Act § 88.001(10). *See also* J.A. 152-54 and n.19 (Aetna's argument that McCarran-Ferguson Act preempted plaintiffs' RICO claims in MDL litigation, as state insurance laws "do not merely regulate remedies for concededly wrongful conduct. Instead, they address the very core of state insurance regulation: what conduct by an insurer is (or is not) permissible. . . .").

Even before *Kentucky Association*, the Court observed—in rejecting an insurer's challenge to California's notice-prejudice rule—that if insurers "could displace any state regulation simply by inserting a contrary term in plan documents," the saving clause would be "virtually" read out of ERISA. *UNUM*, 526 U.S. at 376 and n.6 (recognizing that "applying the States' varying insurance regulations creates disuniformities for national plans," but that "such disuniformities are the inevitable result of the congressional decision to 'save' local insurance regulation") (internal punctuation, citation omitted). The same is true here: HMOs cannot displace state regulation of insurance and health-care matters by inserting a contrary term—making themselves the sole arbiter of medical necessity and then claiming effective

immunity from review of an erroneous decision—in documents that are not even the ERISA "plan."

B. The federal-law exception and the McCarran-Ferguson Act.

The concluding paragraph of § 514 provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States. . . ." One of those federal laws is of course the McCarran-Ferguson Act, 15 U.S.C. § 1012, which provides, in subsections (a) and (b), respectively, that "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the regulation . . . of such business," and that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . ." Taken together, the concluding provision of § 514 and the McCarran-Ferguson Act further show Congress's overall intent to leave state insurance regulation squarely within the states' domain. *Metropolitan Life*, 471 U.S. at 744 n.21.

Congress spoke unequivocally when it saved state laws regulating the business of insurance from preemption; it provided that federal law—including the McCarran-Ferguson Act's clear reservation of insurance-related regulation to the states—remained unaffected by ERISA; and with its decisions in *Rush Prudential* and *Kentucky Association*, the Court has reaffirmed the primacy of state insurance regulation.

IV. Judicially implied preemption should not trump an express exception to preemption delineated by Congress.

A. Applying judicially implied complete preemption here ignores the plain text of both the saving clause and federal-law exception, and violates the separation of powers.

1. Starting with the *Travelers* trilogy in the mid-1990s, the Court curtailed the implication from its earlier rulings that § 514(a) "relates to" preemption had an infinite reach. Now foreclosed for several reasons from advancing previously all-encompassing "relates to" preemption under ERISA's only express-preemption clause, the HMOs urge judicially implied complete preemption under Section 502(a), and attempt to give judicially implied preemption the same infinite reach the Court has more recently found Congress never intended in § 514(a). If Petitioners' argument is adopted, Section 502 judicially implied complete preemption will now sweep away practically every state law, including those expressly saved from preemption.

It is to be hoped that Petitioners will concede that the Texas Act is a state insurance law saved from § 514 preemption under *Rush Prudential* and *Kentucky Association*. Petitioners are left asking for a doctrine created by judicial implication to override an express saving clause. Yet one cannot ignore the passage shortly following *Rush Prudential*'s comments anticipating a "forced choice" between a saving clause and *Pilot Life's* language about exclusive remedies: "We think, however, that [the HMO] overstates the rule expressed in *Pilot Life*." *Rush Prudential*, 536 U.S. at 378. *See also Taylor*, 481 U.S. at 67 (Brennan, J., concurring) ("I write separately only to note that today's holding is a narrow one.").

In fact, the United States' *amicus* brief in *UNUM* correctly recognized that the language in *Pilot Life* sometimes read to preempt even causes of action under laws regulating insurance was *dicta*, "unnecessary to *Pilot Life's* holding that the law at

issue there was not in any event an insurance regulation within the meaning of that provision." Br. of United States 20, 1998 WL 839957, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868). The Solicitor General went on to properly construe § 502 as not trumping the insurance saving clause: "Accordingly, the savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA, shall be 'construed' to relieve or exempt any person from 'any law' of a State that regulates insurance." *Id.* at 23. Thus, according to the Government, "the insurance savings clause, on its face, *saves state law conferring causes of action or affecting remedies* that regulate insurance. . . ." *Id.* (emphasis added).

Of course, even under a broader reading *Pilot Life* and *Taylor* are not helpful to the HMOs in overcoming the insurance saving clause. *Pilot Life* and *Taylor* contain three holdings not applicable here: (1) The state's general law in each instance was not specifically directed toward the insurance industry and thus not saved as a "law regulating the business of insurance"; (2) the state law supplied additional remedies *only* for an inarguably duplicate claim for the continued withholding of benefits; and (3) the state law did not regulate areas and duties distinct from those found in ERISA. The Texas Act is distinguishable on all three points; the saving-clause language is clear.

2. Justice Frankfurter's salutary quote of Justice Holmes obtains: "[Previously] I was indiscreet enough to say I don't care what [the legislature's] intention was. I only want to know what the words mean." Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 Colum. L. Rev. 527, 538 (1947). Congress could of course have made these cases even easier if, in enacting the saving clause, it had said, "Do not preempt Texas's and other states' regulation of HMOs and their medical-necessity decisions," or, "Do not preempt the Texas Act." But the saving clause is just as explicit, and more expansive in its effect; Congress unequivocally preserved "*any law of any State*

which regulates insurance," and proceeded to define "State law" in § 514(c)(1) to mean "*all* laws . . . or other State action having the effect of law"—a formulation that clearly includes in its broad definition of "State law" private causes of action against risk-bearing or risk-adjusting entities, and other state enforcement devices constituting a state's "laws" regulating insurance.

The HMOs seek to add by judicial implication a phrase to the saving clause that Congress most assuredly did not include, given the unambiguous words actually used. Congress saved "any" and "all" "laws regulating the business of insurance" (and through the federal exception and the McCarran-Ferguson Act, "all laws of the several States which relate to the regulation" of the "business of insurance")—to which the HMOs would add "except for all state-law insurance remedies." Congress did not of course include any such phrase; and the judiciary should not rewrite the saving clause and the McCarran-Ferguson Act to do what Congress did not, because that is judicial legislation. "Were the power of judging joined with the legislative, the life and liberty of the subject would be exposed to arbitrary controul, for *the judge* would then be *the legislator*." The Federalist No. 47, at 326 (James Madison) (J. Cooke ed. 1961) (citation omitted).

If Petitioners were to prevail, four legislative actions—ERISA's saving clause, ERISA's federal-law exception, the McCarran-Ferguson Act, and the Texas Act—would be overridden by a judicially implied doctrine. The democratic will of Congress and state legislatures should not be frustrated by "implied" exceptions not founded in the congressional enactment, as this would (among other indignities) violate the Constitution's separation of powers. The Court has never gone so far with an implied exception to the plain text of an express saving clause.

3. Going beyond the saving clause's express text would also require concluding that Congress, without saying so anywhere in ERISA or its legislative history, implicitly negated

various existing state-law insurance remedies. In effect in late August of 1974 were at least 14 insurance statutes in at least 12 states that included separate remedial enforcement provisions; several provided a private cause of action. *See* S.D. Codified Laws § 58-33-46.1 (1974) (private right of action); 1973 Tex. Gen. Laws, ch. 22, sec. 3, art. 21.21, § 16 at 395-6 (since codified at Tex. Ins. Code Ann. art. 21.21, § 16 (2003)) (private right of action); Kan. Stat. Ann. § 40-3111 (1974) (private right of action); 215 Ill. Comp. Stat. 5/155 (2003) (formerly Ill. Rev. Stat. 1967, ch. 73, par. 767) (private right of action); 215 Ill. Comp. Stat. 5/431 (1967); Tenn. Code Ann. § 56-7-105 (1955) (private right of action); Mo. Ann. Stat. § 375.420 (1939) (private right of action); Mo. Ann. Stat. § 375.942 (1959); Ga. Code Ann. § 33-6-8 (1960); Ind. Code § 27-4-1-6 (1947); Pa. Stat. Ann. tit. 40, § 1171.11 (1974); Conn. Gen. Stat. § 38a-817 (2003) (formerly Conn. Gen. Stat. § 38-62 (1971); Ark. Code Ann. § 23-66-210 (1959); Mass. Gen. Laws Ann. ch. 176D, § 10 (1972).

One cannot infer from the state insurance regulatory landscape extant in 1974 that Congress somehow thought state laws regulating insurance lacked remedies provisions. To exclude those state remedies from the scope of the insurance saving clause in 1974, Congress had to say so. It did not.

4. There is of course another presumption closely related to the one against preemption, both of which have their roots in notions of federalism, and which further shows that allowing judicial implication to trump express exceptions to preemption would be error in these cases: the presumption that every law enacted by a state government is constitutional. *E.g.*, *Kelley v. Johnson*, 425 U.S. 238, 247 (1976) (noting presumption of legislative validity concerning matters within state's police power); *Atchison, T. & S.F. R. Co. v. Matthews*, 174 U.S. 96, 104 (1899) ("It is . . . a maxim of constitutional law that a [state] legislature is presumed to have acted within constitutional limits"). These rules derive from the states' role as separate sovereigns in our federal system. *See supra* Part I.B; *see also*

Geier, 529 U.S. at 907 (Stevens, J., dissenting) (noting that "the structural safeguards inherent in the normal operation of the legislative process operate to defend state interests from undue infringement"; the presumption "serves as a limiting principle that prevents federal judges from running amok with our potentially boundless (and perhaps inadequately considered) doctrine of implied conflict preemption . . ."). The Texas Act must be presumed to be—and is—a constitutional exercise of Texas's police power in our federal system.

B. The Court's rare finding of implied conflict preemption, but never complete preemption and thus removability, when a saving clause is present.

1. In this Court, judicially implied preemption has never supported removal where a statute's saving clause applied.[29] Only rarely has the Court implied even *conflict* preemption in the face of a saving clause. The uncommon occasions on which the Court has implied defensive conflict preemption in the presence of a saving clause supplies a ground for decision here that yields no reason for implied preemption to trump the insurance saving clause or the McCarran-Ferguson Act.

The Supremacy Clause nullifies "saved" state law only where that law either prevents or frustrates the accomplishment of an explicit federal objective, or makes it impossible for private parties to comply with both state and federal law. *See*, *e.g.*, *Geier*, 529 U.S. at 873-74; *United States v. Locke*, 529 U.S. 89 (2000)

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29. Though *Rush Prudential* pronounced that a plaintiff who succeeded in getting an IRO reviewer to agree that a particular treatment was medically necessary was then left with a § 502(a)(1)(B) action to recover "benefits," the plaintiff did not cross-petition the Seventh Circuit's decision that her removed claim to enforce the IRO decision was such a claim. *See* Br. of the American Medical Ass'n *et al.* as *Amici Curiae* 19, *Rush Prudential*, 536 U.S. 355 (No. 00-1021). Consistent with the plaintiff's acquiescence in that holding, the parties' briefing simply assumed that § 502(a)(1)(B) applied; the dispute revolved around whether the IRO provisions impermissibly added to ERISA's remedies, with the Court holding that they did not.

(finding various state tanker-related regulations preempted by comprehensive federal regulatory scheme governing tankers but concluding that other state regulations might not be preempted); *American Tel. & Tel. Co. v. Central Office Tel., Inc.*, 524 U.S. 214, 227-28 (1998) (common-law right is not "saved" if it would be "absolutely inconsistent with the provisions of the act"); *Freightliner Corp. v. Myrick*, 514 U.S. 280, 287, 289 (1995) (federal act contained both express-preemption provision and saving clause, but holding no implied preemption where federal standard regulating ABS devices on vehicles did not exist, thus no frustration of federal law or impossibility of complying with both federal and state law); *Ouellette*, 479 U.S. at 494, 497 (holding that federal Clean Water Act, which extensively regulates water pollution, does not preempt pollution law of source state, thereby giving force to an express saving clause while finding preemption of another state's nuisance law); *Chicago and North Western Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311 (1981) (holding that Interstate Commerce Act's exclusive regulation of abandoned rail lines impliedly preempted state-law claim concerning same subject).

The HMOs do not argue that it is impossible for them to comply with both ERISA and the Texas Act, as indeed it is not. *Cf. John Hancock Mut. Life*, 510 U.S. at 98 ("ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized or accommodated").

2. Without a conflict—that is, an impossibility of complying with both ERISA and the Texas Act—the HMOs are left to argue for judicially implied, saving-clause-trumping preemption on a more amorphous basis from the penumbras of ERISA's "scope and purpose," despite the lack of any substantive ERISA regulation of HMOs' medical decisions. But ERISA's explicit scope and purpose do not help the HMOs in their endeavor.

ERISA's objectives are found most clearly in its opening section, 29 U.S.C. § 1001, which focused on the then-prevailing

situation in which employees were "losing anticipated *retirement* benefits" (emphasis added) and declared ERISA's policy to be the protection of "the interests of participants in employee benefit plans and their beneficiaries." Subtitle B, 29 U.S.C. §§ 1021-1144 deals heavily with *pension-plan* regulation, and says little about welfare plans. Part 4 ("Fiduciary Responsibility") of that subtitle, though not expressly limited to pension plans (*cf.* 29 U.S.C. §§ 1051, 1081), is significantly limited by *Pegram* to have any arguable application to HMOs, which are not employers, plan sponsors, or fiduciaries in this context. Section 502(a)(1)(B) is also within Subtitle B, but § 502 contains further language illuminating congressional intent regarding the boundaries of field preemption. Section 502(d)(2), for example, provides that "[a]ny money judgment" is "enforceable only against the plan as an entity," and is "not enforceable against any other person unless liability . . . is established in his individual capacity [*i.e.*, as a fiduciary] under this subchapter." 29 U.S.C. § 1132(d)(2).

In contrast to pension plans, an area without "strong state-law roots," ERISA does not comprehensively regulate non-pension plans; welfare-plan benefits (such as health care), "long governed under the states' police powers, have never been viewed as a peculiarly federal concern." Bogan, *supra* n.23, 74 Tul. L. Rev. at 956-57 (citing *Travelers*). The Court's observation that ERISA is a "comprehensive and reticulated statute" (*e.g.*, *Alessi*, 451 U.S. at 510) initially arose—quite accurately—in the context of pension-plan cases, but extending this formulation to cases involving non-pension benefits is demonstrably wrong even if the benefit is seen not as payment of the HMO membership dues or premiums, but as the health care the HMOs agree to arrange for and provide.

In addition, early versions of ERISA included removal provisions, but the enacted version omitted them, without any explanation in the Conference Report. *See*, *e.g.*, H.R. 2 at 96, *reprinted at* 1 Leg. Hist. at 188 (authorizing Secretary of Labor or ERISA-plan participant to remove under certain

circumstances); S.4 at 196, *reprinted in* 1 Leg. Hist. at 584 (same); amendment to S.4 at 222-23, *reprinted in* 1 Leg. Hist. at 1492-93 (authorizing Secretary to remove); H. Rep. No. 93-533 at 155-56, *reprinted in* 2 Leg. Hist. at 2335-36 (allowing any party to remove); H.R. 2 at 151, *reprinted in* 3 Leg. Hist. at 4048 (also allowing any party to remove).

The absence of any removal provision in the final version of ERISA is consistent with Congress's grant of concurrent jurisdiction to state and federal courts.[30] And it is also consistent with Congress's statement that it intended, with ERISA's enforcement provisions, "to provide the *full range of legal and equitable remedies available in both state and federal courts* and to remove jurisdictional and procedural obstacles which in the past appear to have hampered . . . recovery of benefits due to participants." Senate Comm. on Labor and Public Welfare, S. Rep. No. 93-127 at 35, *reprinted in* 1 Leg. Hist. at 621 (emphasis added). Nowhere within ERISA's scope, purpose, or structure did Congress signal an intent to preempt state regulation of health-care matters generally, and of HMO medical decisions specifically.

3. It bears repeating: declining to apply judicially implied complete preemption to Respondents' claims in no way requires that *Pilot Life* and *Taylor* be overruled, but merely left unexpanded into an area that Congress never intended to preempt.

The HMOs bridge the chasm between the actual holdings of *Pilot Life* and *Taylor* on the one hand and the Texas Act on the other by a precariously cantilevered contraption: ignore the strong presumptions against preemption and in favor of constitutionality; ignore the statutorily expressed overriding purpose of ERISA to protect beneficiaries; ignore the well-pleaded-complaint rule; ignore Congress's explicit saving

30. Section 502(e)(1), 29 U.S.C. § 1332(e)(1), is thus unlike LMRA § 301, 29 U.S.C. § 185(a), which provides that "[s]uits for violation for contracts between an employer and a labor organization . . . may be brought in any district court of the United States. . . ."

clause; re-characterize the facts to fit broad *dicta* about "processing benefits"; and ignore the holdings of *Pegram* and *Rush Prudential*. Cantilevers collapse if not precisely engineered so they do not project out too far. The HMOs' contraption fails because it extends too far, by ultimately asking the Court to make law, not interpret it, something that happens when a judge "extends his precedents, which were themselves the extension of others, till, by this accommodating principle, a whole system of law is built up without the authority or interference of the legislator." Robert Rantoul, Oration at Scituate (July 4, 1936), *quoted in* Kermit L. Hall *et al.*, American Legal History 317, 318 (1991). Just so here, if judicially implied preemption is allowed to overcome the saving clause's plain text.

Stare decisis is honored by following *Pilot Life* and *Taylor* when there is a truly duplicate claim for ongoing withholding of benefits against an ERISA plan or fiduciary. If the state law substantively regulates medical decision-making or falls within the insurance saving clause and the McCarran-Ferguson Act exception, though, it is not preempted, and at a minimum there is no removal preemption. This does no violence to *Pilot Life* and *Taylor*, while giving full effect to what Congress did and did not say.

V. A holding of no implied complete preemption here would not undermine uniformity, disturb "settled expectations" or increase insurance costs.

1. The illogic of making "uniformity" the *sine qua non* of ERISA preemption in the case of employee-welfare benefits as opposed to pension benefits is shown principally by the fact that ERISA does not set out detailed requirements for the former, as it does with the latter. If Congress meant to invest ERISA with some substantive principles concerning medical necessity, thus justifying wholesale preemption of state health-care law, it failed miserably; both the statute and Department of Labor regulations are completely mute on the point.

Too, there are thousands of health-insurance and managed-care entities operating in the United States, *see* Rosenblatt at

545, each imposing its own (disuniform) definition of "medical necessity." *Compare* J.A. 54-55 (Aetna's definition of medical necessity) *with* J.A. 236 (CIGNA's definition); *see also* J.A. 300 (Aetna's statement from brief in Florida MDL litigation that "[t]he precise presentations made to health plan members about the scope of 'medically necessary' care available to them vary considerably," and quoting various state statutes defining medical necessity differently); J.A. 301 (similar excerpt from CIGNA brief). A "uniform" idea of medical necessity is paradoxical when it turns entirely on the vagaries of which HMO a patient happens to belong to. *See also* Chamber Br. 20-21 (recognizing that through valid IRO mechanisms, states can impose as many as 50 different standards of medical necessity).

Part of the difficulty surely lies in the very nature of medical-necessity decision-making: what is appropriate for one patient may not be so for the next, a point the Department of Labor made in its *Pappas* brief: "[A]llowing state law challenges to medical judgments made in the context of an HMO's mixed treatment and eligibility decisions should not defeat ERISA's goal of ensuring that plans and plan sponsors would be subject to a uniform body of benefits law. . . ." DOL Br., 2000 WL 34016555 at *13 (Sept. 22, 2000), *Pappas*, 768 A.2d 1089. State tort law "would not threaten uniformity because the determination is an individualized decision that dictates nothing regarding the treatment to be afforded in the next individualized case." *Id.* at *14 (internal quotation marks, citation omitted). *See also* Stempel, *supra* n.14, 36 Tort & Ins. L. J. at 696-97 (ERISA stresses substantive remedies to protect retirement benefits more than it does uniformity). Justice Frankfurter had it exactly right when he cautioned against "the deceptive lure of certainty and comprehensive symmetry," recognizing that there are "demands more inclusive than those for mechanical uniformity." *Wilburn Boat Co. v. Fireman's Ins. Co.*, 348 U.S. 310, 324 (1955) (Frankfurter, J., concurring).

2. It is of course not only HMOs and employers that have an interest here: millions of patients also have "settled

expectations," Aetna Br. 41, that their state governments will protect their safety when it comes to medical decision-making. More fundamentally, the states and their citizens, litigants, and lower courts have settled expectations as well that constitutional principles of federalism will be respected.

And it was not until 1992 that a court first used ERISA to immunize a utilization-review entity from its medical decisions. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). Beginning three years later, with the *Travelers* trilogy, the Court began to cast doubt upon notions of sweeping ERISA preemption. Since *Corcoran*, numerous courts have struggled mightily with if and how to apply preemption to HMOs, with disparate results. *E.g.*, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam); *Pappas*, 768 A.2d 1089; *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied sub nom. U.S. Healthcare, Inc. v. Bauman*, 530 U.S. 1242 (2000); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286 (11th Cir. 2003), *petition for cert. filed*, 72 U.S.L.W. 3310 (U.S. Oct. 28, 2003) (No. 03-649). This is but a small sample of the many contradictory HMO ERISA-preemption cases across the country—hardly the stuff of "settled expectations."

3. Empirical data show that Petitioners' claim that deferring to Texas's (and other states') traditional role in regulating health-care and insurance matters would increase health-care costs is wrong. The Congressional Budget Office estimated that under the then-proposed Patients' Bill of Rights Act of 1998, the effect of formally and explicitly extinguishing ERISA preemption would result in only a 1.2% increase in health-plan premiums. Congressional Budget Office Cost Estimate—H.R. 3605/ S. 1890, *available at* www.cbo.gov/showdoc.cfm (July 16, 1998). *See also* Kaiser Family Foundation, "Impact of Potential Changes to ERISA: Litigation and Appeals Experience of CalPERS, Other Large Public Employers, and a Large California Health Plan," *available at* www.kff.org/statepolicy/1415-erisa.cfm (June 1998) (showing costs of no more than $.13 per

member per month attributable to public employees' existing ability to sue managed-care plans); CBO, *Limiting Tort Liability for Medical Malpractice* 7, *available at* ftp://ftp.cbo.gov (Jan. 8, 2004) (available evidence "does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency."). Further, even though ERISA has never been construed to create HMO immunity in the case of state, county, and school-district employees, there is no evidence that premiums for those classes of insureds differ from those paid by private-sector insureds receiving HMO membership through an employer.

Texas's experience following the 1997 enactment of the Act is particularly instructive. The American Medical Association, for example, noted figures from the Texas Department of Insurance showing that average per-member per-month HMO premiums fell 1.3% in 1998, the year after the Texas Act was passed. They rose nearly 5% in 1999 and about 9% in the first three quarters of 2000. In contrast, HMO premiums nationwide rose an average of 1.6% in 1998, 5.4% in 1999, and 9.6% in 2000. *Texas Trial: HMO Liability Law*, *available at* www.ama-assn.org/amednews/2001/05/28/gvsa0528.htm (May 28, 2001). *See also* Mark A. Hall & Gail Agrawal, "The Impact of State Managed Care Liability Statutes," *Health Affairs*, Vol. 22, Issue 5, 138-145 (2003) (study of six states, including Texas, that have adopted varying types of managed-care patient-protection laws shows that fears of "flood of litigation" that would increase health-insurance costs by roughly 5 percent has not been "borne out by experience."). Even if the tocsins that HMOs routinely sound in response to laws holding them accountable were factually based, such warnings do not justify the draconian result Petitioners here seek of leaving patients with no way to recover for HMO medical malpractice.

As well, United HealthCare, the nation's second-largest managed-care company, decided in 1999 to virtually eliminate prospective medical-necessity utilization review. *See* Comment,

What's the Appeal? Trying to Control Managed Care Medical Necessity Decisionmaking Through a System of External Appeals, 149 U. Pa. L. Rev. 873, 915 (2001). From United HealthCare's decision, the apparent inefficiencies associated with utilization review can reasonably be viewed as at least as important in driving premium costs as any (unfounded) concerns about potential litigation.

Finally, going over the head of the Texas Legislature for judicially imposed tort reform is hardly necessary. Since 1994, Texas has passed numerous pieces of tort-reform legislation limiting plaintiffs' recovery, limiting access to the courts, eliminating claims, and capping recoverable damages. Resp't App. D (listing 45 examples of Texas tort-reform legislation passed in the last decade). If HMOs do in fact become subject to disproportionate verdicts and judgments, Texas has shown itself without peer in the area of tort reform. The Legislature's willingness to enact multiple tort reforms should at least give pause when one considers that the Texas Act contains the only significant new cause of action Texas has adopted in the last decade. Even in a decade of dramatic tort reform, the Legislature determined that the problem of lack of HMO accountability for defective medical decisions was particularly acute.

CONCLUSION

In explaining the need for the Texas Act, sponsoring state senator David Sibley said this:

> Health care delivery in the United States has changed, it's no longer the same as it was. * * * You . . . have a third party [HMO] now who has . . . insinuated themselves into the treatment room and into the operating room, and into the examination room. * * * *If people are gonna stand in the shoes of the doctor and make decisions that chart the course of treatment, I think they oughta be held accountable. . . .* [Resp't App. C, transcript of March 17, 1997, Texas Senate proceedings on S.B. 386 at 1, 5 (emphasis added).]

Aetna and CIGNA want *not* to be held accountable, and they seek that result by asking the Court to render the Texas Act a nullity with regard to HMO medical-care decisions, and through contorted application of a federal employee-protection statute that was never meant, under any construction, to usurp a state's right to regulate medical-care and insurance issues within its border. And this is not, contrary to Petitioners' suggestion, an issue for Congress to fix. It can and should be resolved by doing nothing more than applying fundamental principles of statutory construction.

For all the reasons discussed, the Fifth Circuit's decisions below should be affirmed.

Respectfully submitted,

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APPENDIX A — CIGNA CONTRACT PROVISIONS SAMPLE

Excerpts of Cigna Form Contract Provisions[1]

STATE OF TEXAS §
§
COUNTY OF TRAVIS §

The commissioner of Insurance, as the chief administrative and executive officer and custodian of records of the Texas Department of Insurance has delegated to the undersigned the authority to certify the authenticity of documents filed with or maintained by or within the custodial authority of the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

Therefore, I hereby certify that the attached documents are true and correct copies of the documents described below. I further certify that the documents described below are filed with or maintained by or within the custodial authority of

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[1] Cigna contract provisions quoted in Appendix "A" (pages 1a-8a) of this Appendix are *excerpts* from the certified original documents filed with the Texas Department of Insurance ("TDI") by Cigna Healthcare of Texas, Inc. in 1999. Aetna contract provisions quoted in Appendix "B" (pages 9a-25a) are *excerpts* from the certified original documents filed with TDI by Aetna Health, Inc., in 1999 and 2000. Appendix "E" is the Texas Act § 88.001, *et seq*. Cigna and Aetna do not object to the inclusion of the materials in Respondents' Appendices "A," "B," "C" and "D" even though they do not appear in the record below (just as Aetna's Formulary does not appear in the record below, see Aetna App. 26a-40a).

the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

The certified documents consist of complete copies of form filings submitted by Cigna Healthcare of Texas, Inc. in 1999.

This certification does not include records relevant to an inquiry, if any, by the Texas Department of Insurance's Insurance Fraud Unit which are confidential pursuant to Tex. Ins. Code art. 1.10D. § 5(a) and an Op. Tex. Att'y Gen. No. OR95-1536 (1995).

IN TESTIMONY WHEREOF, witness my hand and seal of office at Austin, Texas, this 17th day of December, 2003.

JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

[seal]

BY: /s/
Olga Escobedo, Director
HMO Compliance/URA/IRO Section
HMO Division
Life, Health & Licensing Program

[CIGNA's] MANAGED CARE ALLIANCE AGREEMENT

PARTIES _____

This Agreement is by and between CIGNA HealthCare of _____, Inc. ("CIGNA") and _____ ("MCA") and is entered into as of the Effective Date.

* * *

I. DEFINITIONS

* * *

Medically Necessary means services and supplies which under the terms of the applicable Service Agreement are "Medically Necessary. Covered Services must be Medically Necessary." [pages 2, 3]

* * *

ELECTION TO PARTICIPATE WITH CIGNA HEALTHCARE OF _____ AND AFFILIATES

* * *

3. **CIGNA Programs, Policies and Procedures**. You agree to cooperate with, and abide by CIGNA's programs, procedures, and policies, including but not limited to those regarding billing, provider credentialing, utilization

management, quality assurance, medical record keeping and Participant grievances and appeals. [page ETP-1]

* * *

EXHIBIT B
HMO PROGRAM ATTACHMENT – CAPITATION
UTILIZATION MANAGEMENT

1. MCA will establish a Utilization Management program (the "UM Program") in accordance with CIGNA's standards, NCQA standards or the standards of another appropriate accrediting body designated by CIGNA, and Program Requirements. MCA shall maintain any licensure required in connection with its UM Program activities, and its UM Program shall comply with all requirements of applicable laws.

2. MCA's UM Program shall seek to assure that health care services provided to Participants are Medically Necessary and will include, but not be limited to the following: management of referrals between the Primary Care Physician and specialist, prior authorization and case management of outpatient facility based services, prior authorization and case management of inpatient services, discharge planning, major condition case management, and utilization information management.

* * *

6. CIGNA shall have the right to audit MCA's utilization management activities upon reasonable prior notice. MCA shall cooperate with any such audits.

* * *

9. The parties acknowledge and agree that CIGNA or Payor shall have final decision making authority with regard to appeals of utilization management decisions. [page HMO-EXB – 1]

MEDICARE PROGRAM ATTACHMENT
TO
[CIGNA'S] MANAGED CARE ALLIANCE
AGREEMENT
(CAPITATION)

EXHIBIT B

MEDICARE PROGRAM ATTACHMENT –
CAPITATION
UTILIZATION MANAGEMENT

(delegation of utilization management)

1. MCA will establish a Utilization Management program (the "UM Program") in accordance with CIGNA's standards, NCQA standards or the standards of another appropriate accrediting body designated by CIGNA, and Program Requirements. MCA shall maintain any licensure required in connection with its UM Program

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activities, and its UM Program shall comply with all requirements of applicable laws.

2. MCA's UM Program shall seek to assure that health care services provided to Participants are Medically Necessary and will include, but not be limited to the following: management of referrals between the Primary Care Physician and specialists; prior authorization and case management of outpatient facility based services, prior authorization and case management of inpatient services, discharge planning, major condition case management, and utilization information management.

* * *

6. CIGNA shall have the right to audit MCA's utilization management activities upon reasonable prior notice. MCA shall cooperate with any such audits.

* * *

9. The parties acknowledge and agree that CIGNA or HCFA, as applicable, shall have final decision making authority with regard to appeals of utilization management decisions. [pages EXB – 1, EXB – 2]

Appendix A

EXHIBIT B
MEDICARE PROGRAM ATTACHMENT –
CAPITATION
UTILIZATION MANAGEMENT
(no delegation of utilization management)

MCA and its Represented Providers shall comply with the requirements of CIGNA's Utilization Management program . . . [page EXB – 1]

[CIGNA's]
PARTICIPATING PHARMACY AGREEMENT

PARTIES

THIS AGREEMENT is by and between CIGNA HealthCare of Texas, Inc. ("Healthplan"), and the Pharmacy ("Pharmacy") whose name appears below and is entered into as of the Effective Date.

* * *

2. *Pharmacy's Responsibilities*

* * *

i. Pharmacy will cooperate and participate in Healthplan's quality assurance, utilization review, and grievance programs, which are described in Program Requirements. [pages 1, 2, 3]

APPENDIX B — AETNA CONTRACT PROVISIONS SAMPLE

Excerpts of Aetna Form Contract Provisions

STATE OF TEXAS §
§
COUNTY OF TRAVIS §

The commissioner of Insurance, as the chief administrative and executive officer and custodian of records of the Texas Department of Insurance has delegated to the undersigned the authority to certify the authenticity of documents filed with or maintained by or within the custodial authority of the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

Therefore, I hereby certify that the attached documents are true and correct copies of the documents described below. I further certify that the documents described below are filed with or maintained by or within the custodial authority of the HMO Compliance/URA/IRO Section, HMO Division, Life, Health & Licensing Program of the Texas Department of Insurance.

The certified documents consist of copies of several form filings that were filed by Aetna Health, Inc., in 1999 and 2000.

This certification does not include records relevant to an inquiry, if any, by the Texas Department of Insurance's Insurance Fraud Unit which are confidential pursuant to Tex. Ins. Code art. 1.10D. §5(a) and an Op. Tex. Att'y Gen. No. OR95-1536 (1995).

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IN TESTIMONY WHEREOF, witness my hand and seal of office at Austin, Texas, this 17th day of December, 2003.

JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

[seal]

BY: _____
Olga Escobedo, Director
HMO Compliance/URA/IRO Section
HMO Division
Life, Health & Licensing Program

Appendix B

1. Documents filed in 2000

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] PRIMARY CARE PHYSICIAN AGREEMENT

Dear Primary Care Physician:

Welcome to the Aetna U.S Healthcare provider network! We are delighted that you have decided to join our provider network as a participating primary care physician.

We mutually desire to enter into an agreement under which you, the licensed physician signing below ("You" or "Physician"), will furnish Primary Care Services and arrange for and coordinate the provision of other health services to Members to achieve our shared objective of providing our Members and your patients with access to quality health care services. Physician agrees to abide by the quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). [page -1-]

* * *

Appendix B

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Physician and Company of providing Members with access to and promotion of quality health care services. Physician shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS®") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations. Company will provide ninety (90) days prior written notice of material

changes in policies and procedures. In addition, Physician shall participate in Company's preventive care program or implement an effective preventive care program consistent with Company's criteria and policies, for which Physician shall be compensated in accordance with the Physician Compensation Model as described in the Compensation Schedule.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Providers.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria).

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission to notify the Company thereof. [pp. 4,5]

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] FACILITY AGREEMENT

* * *

4.0 COMPLIANCE WITH COMPANY RULES, POLICIES AND PROCEDURES

4.1 Compliance and Participation. Facility shall comply fully with the rules, policies and procedures that Company has established or will establish, including but not limited to, those regarding: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, and referral process or protocols; (c) claims payment review; (d) Member grievances; (e) provider credentialing; and (f) electronic submission of claims and other data required by Company. Facility shall comply with and be bound by

Appendix B

the Participation Criteria set forth in the **Participation Criteria Schedule.** Facility acknowledges and agrees that failure to comply with Company's rules, policies and procedures may adversely affect any compensation due hereunder and could lead to sanctions including, without limitation, termination of this Agreement. Company will provide ninety (90) days prior written notice of material changes in policies and procedures.

4.2 *Utilization Review.* Company utilizes systems of utilization review/quality improvement/peer review consistent with applicable federal and state laws to promote adherence to accepted medical treatment standards and to encourage Participating Providers to control medical costs consistent with sound medical treatment. To this end, Facility agrees:

a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) with respect to all Members. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Providers.

b) To provide telephone notice to Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services.

c) To provide clinical data and information to Company as is necessary to permit Company to conduct utilization review.

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d) To permit a Company home care coordinator to assist in on-site assessments of Members for purposes of discharge planning, when required by Company.

e) To allow Company to conduct concurrent on-site review, when required by Company.

f) To provide upon Company's request complete copies of Members' medical records.

(g) To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment.

Noncompliance with any requirements of this Section 4.2 will relieve both Payors and Members from any financial liability for all or any portion of the services provided. [pages 4, 5]

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[AETNA's] SPECIALIST PHYSICIAN AGREEMENT

* * *

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Physician and Company of providing Members with access to and promotion of quality health care services. Physician shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** and Company's then-current Policies regarding, among other things: (a) quality improvement/management/ assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) Physician credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/Utilization Review Accreditation Commission ("URAC"),

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Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations. Company will provide ninety (90) days prior written notice of material changes in policies and procedures.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Physicians to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Physicians.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria).

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e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment. [page -5-]

2. Documents filed in 1999

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] PRIMARY CARE PHYSICIAN AGREEMENT

Dear Primary Care Physician:

Welcome to the Aetna U.S Healthcare provider network! We are delighted that you have decided to join our provider network as a participating primary care physician.

We mutually desire to enter into an agreement under which you, the licensed physician signing below ("You" or "Physician"), will furnish Primary Care Services and arrange for and coordinate the provision of other health services to Members to achieve our shared objective of providing our Members and your patients with access to quality health care services. Physician agrees to abide by the quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance

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organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). [page 1]

* * *

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Provider and Company of providing Members with access to and promotion of quality health care services. Provider shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** (attached hereto and made a part hereof) and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS®") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on

Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/ Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs and decisions. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Physicians.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria) to the fullest extent possible.

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission to notify the Company thereof. [pages -4-, -5-]

THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION

[AETNA's] SPECIALIST PHYSICIAN AGREEMENT

Dear Specialist Physician:

Welcome to the Aetna U.S Healthcare provider network! We are delighted that you have decided to join our provider network as a participating primary care physician.

We mutually desire to enter into an agreement under which you, the licensed physician signing below ("You", "Physician" or "Physician"), will furnish Covered Services in the specialized field of _____ (hereinafter called "Specialty") to Members to achieve our shared objective of providing our Members and your patients with access to quality health care services. Physician agrees to abide by the

quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). [page 1]

* * *

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 *Compliance and Participation* Company's Participation Criteria and Policies are necessary to the mutual objectives of Provider and Company of providing Members with access to and promotion of quality health care services. Provider shall comply with Company's then-current Participation Criteria described in the **Participation Criteria Schedule** (attached hereto and made a part hereof) and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances, and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS") and similar data collection and reporting; and (i) information collection and reporting required

or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/ Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations.

4.2. *Utilization Review.* Company's Policies are designed to promote adherence to accepted medical treatment standards and encourage Participating Physicians to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Physician agrees, consistent with sound medical judgment:

a) To participate, as requested, and to abide by Company's then-current utilization review, patient management, quality improvement programs, and all other related programs. As required by Texas law, Company conducts quality assessment through a panel of at least three (3) Participating Physicians.

b) To comply with Company's pre-certification and utilization management requirements for Covered Services.

c) To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

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d) To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria).

e) To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f) To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment. [page 5]

APPENDIX C — EXCERPTS FROM THE TEXAS LEGISLATIVE HISTORY OF S.B. 386

TEXAS SENATE STAFF SERVICES
PAS/108/FLSB386.T1/040497
75TH LEGISLATIVE SESSION
EXCERPT: SENATE BILL 386
MARCH 17, 1997
TAPE 1

1

(Senator Zaffirini Presiding)

PRESIDENT: Chair recognizes the Senator from McLennan County for a motion on the Committee Substitute for Senate Bill 386.

SIBLEY: Thank you Madam President, Members. . . . Health care delivery in the United States has changed, it's no longer the same as it was. . . . You know you have a third party now who has put themselves – having insinuated themselves into the treatment room and into the operating room, and into the examination room.

AG 01522

5

SIBLEY: . . . If people are gonna stand in the shoes of the doctor and make decisions that chart the course of treatment, I think they oughta be held accountable . . .

AG 01526

APPENDIX D — SELECTED TEXAS "TORT REFORM" PROVISIONS ADOPTED IN THE LAST DECADE

Selected "Tort Reform" Provisions Adopted by Texas Legislature and Texas Governor Since 1994

2003

House Bill 4-revised Civil Practice and Remedies Code
Plaintiff reimburses Defendant's attorney's and expert witness fees if Plaintiff refuses settlement and the verdict does not exceed the offer of settlement.

Instead of joining a responsible third party, responsible third party may be designated, which can be anonymous if criminal conduct is involved.

Created rebuttable presumptions for medicines and other products that provide manufacturer immunity from liability for compliance with government standards.

Capped non-economic damages, which include losses for disfigurement, pain and suffering, and impairment, at $250,000 for individual practitioners and $250,000 per single health care institution, not to exceed $500,000.

Decreased the amount of time that medical malpractice Plaintiffs have to file mandatory expert report and eliminated the option for plaintiffs to file a bond in lieu of providing an expert report.

Permits jury to know whether plaintiff was wearing a seat belt for the purpose of allocating fault and determining the cause of damages.

Limits liability of hospitals that provide charity care services.

Requires unanimous verdict of jury to award punitive damages. H.B. 4, 78th Leg., Reg. Sess. (Tex. 2003).

House Joint Resolution 3
Constitutional amendment authorizes legislature to set limits on all damages, except economic damages. H.J.R. 3, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 408–revised Civil Practice and Remedies Code
Increased the number of landowners who receive limited liability under Civil Practice and Remedies Code. H.B. 408, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 705–revised Civil Practice and Remedies Code
Created a rebuttable presumption of no negligence for in-home service companies and residential delivery companies in cases involving criminal acts of employees. H.B. 705, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 1699–revised Civil Practice and Remedies Code
Immunized contractors who construct or repair highways for Dept. of Transportation for personal injury damage or death if the contractor complies with contract documents. H.B. 1699, 78th Leg., Reg. Sess. (Tex. 2003).

House Bill 3439–revised Civil Practice and Remedies Code
Immunized non-compensated healthcare providers from liability for physical exams and screenings at school. H.B. 3439, 78th Leg., Reg. Sess. (Tex. 2003).

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Senate Bill 313–revised Civil Practice and Remedies Code
Protects endowment of not-for-profit religious nursing facilities for payment of damages in civil lawsuits. S.B. 313, 78th Leg., Reg. Sess. (Tex. 2003).

2001
Senate Bill 731–amended Non-Profit Corporation Act
Negated liability of an officer of a non-profit corporation. S.B. 731, 77th Leg., Reg. Sess. (Tex. 2001).

Senate Bill 583–amended Property Code
Permits the filing of liens for services of emergency room physicians. S.B. 583, 77th Leg., Reg. Sess. (Tex. 2001).

1999
House Bill 747–amended the Medical Practice Act
Expanded the medical peer review committee definition. H.B. 747, 76th Leg., Reg. Sess. (Tex. 1999).

House Bill 580–amended Health and Safety Code
Limited the liability for use of a defibrillator while providing emergency care. H.B. 580, 76th Leg., Reg. Sess. (Tex. 1999).

House Bill 1058–amended Civil Practice and Remedies Code
Limits liability of a municipality for specific recreational activities. H.B. 1058, 76th Leg., Reg. Sess. (Tex. 1999).

Senate Bill 717–amended the Civil Practice and Remedies Code
Limits right to bring suit against firearm or ammunition manufacturers, trade associations, or sellers. S.B. 717, 76th Leg., Reg. Sess. (Tex. 1999).

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1997
House Bill 3–amended Health and Safety Code
Provided limited liability for doctors and officers of Healthy Kids Corporation. H.B. 3, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 21–revised Civil Practice and Remedies Code
Provided limited liability for those who donate medical devices to non-profit organization. H.B. 21, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 680-amended Education Code
Provided limited liability for those who donate fire control or rescue equipment to the Texas Forest Service. H.B. 680, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 768–amended Labor Code
Provided additional protections for employers in discrimination claims raising from former employees who allege discharge was related to worker's compensation claim. H.B. 768, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 785–revised Civil Practice and Remedies Code
Provided hospital districts and other taxing entities in non-urban counties right to venue in their home county. H.B. 785, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 1180–amended Natural Resources Code
Provided limited liability for those who install and service liquified petroleum gas systems in motor vehicles. H.B. 1180, 75th Leg., Reg. Sess. (Tex. 1997).

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House Bill 2120–amended Transportation Code
Defined motorist's responsibility in railroad crossing accidents. H.B. 2120, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 2664–amended Civil Practice and Remedies Code
Limited liability of agricultural property owners whose land is used for recreational purposes. H.B. 2664, 75th Leg., Reg. Sess. (Tex. 1997).

House Bill 3087–amended Civil Practice and Remedies Code
Provided protection for defendants against individual with a history of filing litigation. H.B. 3087, 75th Leg., Reg. Sess. (Tex. 1997).

1995

Senate Bill 28–amended Civil Practice and Remedies Code.
Established uniform comparative bar for claimants at greater than 50% in causes of action based on tort, raised the bar by creating several liability where the responsibility of a defendant is greater than 50%, changed joint and several liability for intentional torts to only specified offenses in the Penal Code and permitted a defendant to join third parties and have responsibility submitted jury.

Property owner used for business purposes is liable for injuries to contractors and their employees occurring on the property if the owner has actual knowledge of dangerous condition and exercises control over the manner in which the work is conducted. S.B. 28, 74th Leg., Reg. Sess. (Tex. 1995).

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Senate Bill 25–amended Civil Practice and Remedies Code.
Gross negligence definition replaced with malice definition.

Placed limits on recovery of exemplary damages for fraud, malice and conduct constituting gross neglect in death cases to the greater of $200,000 or two (2) times economic losses plus not more than $750,000 of non-economic losses.

Increased the burden of proof from preponderance of the evidence to clear and convincing evidence for exemplary damages.

Limited request to bifurcate a trial to defendants only.

Limited liability for criminal acts to specific situations, including where the criminal is the defendant and where criminal is an employee of defendant.

Permits jury to consider net worth of defendant in awarding exemplary damages. S.B. 25, 74th Leg., Reg. Sess. (Tex. 1995).

House Bill 971–amended Texas Revised Civil Statute
Enhanced requirements for Plaintiffs to either file a bond within 90 days of filing suit or an expert report per defendant. Within 180 days of filing suit, plaintiffs must file an expert report pertaining to each health care defendant or be dismissed and subject to sanctions, including attorney's fees and forfeiture of security.

Defined expert qualifications of a physician who may testify as an expert witness in a health care liability claim.

Appendix D

Eliminated prejudgment interest on future damages. H.B. 971, 74th Leg., Reg. Sess. (Tex. 1995).

House Bill 668–added a provision to the Deceptive Trade Practices Act
Exempted claims based on rendition of professional services.

Unless defendant acted knowingly, all personal injury and wrongful death damages are excluded. Consumer is limited to economic losses unless the conduct was committed knowingly. Prejudgment interest is excluded on future damages and discretionary damages, trebling of actual damages is discretionary if defendant acted knowingly, mental anguish damages can be trebled only if act was intentional. H.B. 668, 74th Leg., Reg. Sess. (Tex. 1995).

Senate Bill 31–amended the Civil Practice and Remedies Code
Permits sanctions against the party, party's counsel or both for filing frivolous pleadings or motions. S.B. 31, 74th Leg., Reg. Sess. (Tex. 1995).

House Bill 383–amended Texas Tort Claims Act
Expanded to provide protection to elected or appointed officials and employees of local government. H.B. 383, 74th Leg., Reg. Sess. (Tex. 1995).

APPENDIX E — TEXAS HEALTH CARE LIABILITY STATUTE

TEXAS CIVIL PRACTICE AND REMEDIES CODE
TITLE 4. LIABILITY IN TORT
CHAPTER 88. HEALTH CARE LIABILITY

§ 88.001. Definitions

In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

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(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under Chapter 843, Insurance Code.

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

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(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

§ 88.002. Application

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

§ 88.003. Limitations on Cause of Action

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with or otherwise complies with the utilization review requirements of Article 21.58A, Insurance Code, or Chapter 843, Insurance Code, unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsections (c) and (d).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) A review conducted under Subsection (c) as requested by a health insurance carrier, health maintenance

organization, or managed care entity must be performed in accordance with Article 21.58C, Insurance Code. The health insurance carrier, health maintenance organization, or managed care entity requesting the review must agree to comply with Subdivisions (2), (3), and (4), Section 6A, Article 21.58A, Insurance Code.

(e) Subject to Subsection (f), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(f) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (e) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading

was not made in good faith, in which case the court may enter an order pursuant to Subsection (e).

(g) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(h) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.